

# Bowel Screening Standards

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Consultation Report

May 2015



Evidence

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## **About Healthcare Improvement Scotland**

**We believe that every person in Scotland should receive the best healthcare possible every time they come into contact with their health service.**

We have a key role in supporting healthcare providers to make sure that their services meet these expectations and continually improve the healthcare the people of Scotland receive.

We are part of NHSScotland and have four principle functions:

- providing sound evidence for improved healthcare, through the Scottish Medicines Consortium, the Scottish Health Technologies Group, and the Scottish Intercollegiate Guidelines Network
- supporting the delivery of a safer health service and the reliable spread of best practice in quality improvement
- ensuring the effective participation of the public in the design and delivery of healthcare, principally through the Scottish Health Council, and
- scrutinising and quality assuring the provision of healthcare.

Our work programme supports the healthcare priorities of the Scottish Government, in particular those of NHSScotland's Healthcare Quality Strategy and the 2020 Vision.

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## **Background**

The draft standards for bowel screening were published on 8 December 2014, followed by a formal public consultation which concluded on 9 January 2015. The consultation was an opportunity for professional groups, health service staff, voluntary organisations and the public to provide feedback and to influence the further development of the standards.

We approached and received feedback from various professional bodies and voluntary organisations with an interest in bowel cancer services and also healthcare professionals involved in the delivery of bowel screening services in Scotland.

## **Consultation feedback**

We received 123 comments from a variety of sources, including:

- NHS boards
- Royal College of Physicians and Surgeons of Glasgow
- Royal College of Surgeons of Edinburgh
- National Services Scotland
- Scottish cancer networks
- members of the public
- NHS staff
- Crohn's and Colitis UK, and
- Central and West Integration Network.

This document includes all the consultation comments received and the project group's response to each comment.

Healthcare Improvement Scotland would like to thank everyone who submitted comments during the consultation.

| ID no.                    | Consultation comment   | Project group response   |
|---------------------------|--|--|
| Comment on whole document |  |  |
| 1                         | <p>I wanted to draw your attention to the link between Inflammatory Bowel Disease and Cancer.</p> <p>“There is an established link between IBD and an increased risk of developing cancer, primarily in the colon. The risk of colorectal cancer increases with the extent of disease, severity of inflammation, the age of onset and duration of disease, contaminant Primary Sclerosing Cholangitis and family history of bowel cancer. The risk of colorectal cancer at 20, 30 and 40 years after the onset of disease may be as much as 3, 8 and 11% respectively. The risk of patients who have extensive Crohn’s Colitis is similar to that of someone who has extensive Ulcerative Colitis for a similar length of time. There is also an increased risk of small bowel cancer in some people with Crohn’s Disease” (IBD Standards 2013, page 11)</p> <p>The IBD Standards 2013 and British Society of Gastroenterology (BSG) recommend that:</p> <p>“All patients with ulcerative colitis should undergo colonoscopy by year 10 to establish an appropriate pattern and frequency of colon cancer surveillance. The IBD Register should contain a due date for colonoscopy to ensure all patients are offered this service and avoid preventable deaths. Colonoscopy, with systematic mucosal biopsy, should only be performed by a specialist in IBD colonoscopy to a protocol that usually includes dye spray +/- image enhancement.”</p> <p><a href="http://www.bsg.org.uk/clinical/commissioning-report/chronic-inflammatory-bowel-disease.html">http://www.bsg.org.uk/clinical/commissioning-report/chronic-inflammatory-bowel-disease.html</a></p> <p>I hope that, despite missing the deadline, you are able to consider this information and where IBD and cancer surveillance might sit within future bowel screening standards. I would be more than happy to discuss this with you in more detail if this would be helpful.</p> | <p>This comment is outwith the remit of Healthcare Improvement Scotland.</p> |
| Comment on Appendix 1     |  |  |
| 2                         | Change my title to Gastrointestinal Nurse Practitioner.  | Standards document updated.  |

| ID no.  | Consultation comment  | Project group response  |
|---|---|---|
| Comment on project group membership                       |   |   |
| 3   | It is regrettable that the working group included no representative from clinical radiology. Diagnostic radiology (particularly CT colonography) is an important and integral component of a successful bowel cancer screening service, providing a validated alternative to optical colonoscopy in selected cases.   | Andrew MacLeod (Consultant Radiologist, NHS Highland) recruited to provide expertise.       |
| Comments on “Why these standards are important” paragraph |   |   |
| 4   | <p>The following does not seem right: “Together with breast and lung cancers, bowel screening accounts for over 40% of all cancer diagnosed in Scotland in 2012. Each year about 4,000 new cases are diagnosed and 95% of these are people aged 50 years and over. Although death from this disease is falling among men and women, around 1,600 people die of the disease each year in Scotland.”</p> <p>Shouldn't it read 'Together, breast, lung and bowel cancer accounted for more than 40% of all cancer diagnosed in Scotland in 2012'....</p> | Standards document updated.   |
| 5   | <p>Pg. 5, first paragraph within the section entitled 'Why these standards are important'</p> <ul style="list-style-type: none"> <li>• 2nd sentence: 'Together with breast and lung cancers, bowel screening accounts for over 40% of all cancer diagnosed in Scotland in 2012.'</li> <li>• 'In the above sentence, we believe 'screening' should be replaced by 'cancer'.</li> </ul>   | Standards document updated.   |
| 6   | It should be: The Scottish Bowel Screening Programme began in Scotland in 2007 and by December 2009 all NHS Boards were participating in the programme.   | Standards document updated.   |
| Standard 1 – General comments                             |   |   |
| 7   | <p>Annual meeting with public representation</p> <p>- We could invite one of our champions but more representative opinion of patient experience may be obtained through a questionnaire</p>  | This is for local determination, therefore outwith Healthcare Improvement Scotland's remit. |
| 8   | Is there a reason why the standards now don't state how often individuals are invited to take part in the screening process? Previous standards stated every two years. In these standards it just states; in line with the bowel screening pathway.  | Standards document updated.   |

| ID no.                                  | Consultation comment  | Project group response  |
|---|---|---|
| Standard 1 – Standard Statement comment |   |   |
| 9                                       | Standard statement 1 looks more like an assertion than an easily measurable standard. Perhaps it should read 'Scotland is developing an effective bowel screening service.' This is not a major point.  | No change to existing wording.  |
| Standard 2 – General comments           |   |   |
| 10                                      | Recall every 2 years. If still undergoing treatment for bowel cancer, it would be helpful to be told it is unnecessary to do screening and inform the screening service.  | Project group agreed this comment is covered by existing wording.                           |
| 11                                      | Opt out mechanism<br>- Do patients contact Dundee for a disclaimer form?  | Yes, patients should contact Dundee for a disclaimer form.                                  |
| 12                                      | Opt out mechanism<br>- Patients seen in clinic by a clinician to assess their fitness for colonoscopy – should they sign an opt out form?   | This is for local determination, therefore outwith Healthcare Improvement Scotland's remit. |
| 13                                      | RCSEd believes that the barium enema should be phased out and that patients should be offered the less invasive CT Colonoscopy. Although we recognise that limited capacity may mean that this is not always possible.  | Standards document updated.   |
| 14                                      | On the previous standards it was identified that an alternative test could be requested, if individuals are unable to undertake the screening test. Is this still an option? (2a.4 in previous standards).  | There is no alternative test offered.   |
| 15                                      | <ul style="list-style-type: none"> <li>• We believe that the criteria under this standard apply to the Scottish Bowel Screening Centre rather than NHS Boards.</li> <li>• It may be helpful to explicitly state this to avoid potential confusion and uncertainty.</li> </ul>   | Project group disagreed so no changes made to the standards document.                       |
| Standard 2 – Rationale comment          |   |   |
| 16                                      | <p>In the rationale, to help keep language simple and assist understanding the wording “Mortality from bowel cancer” could be replaced with “death caused by bowel cancer.”</p> <p>The third paragraph should read: “Having procedures in place ensures people receive the follow-up appropriate to the outcome of their screening episode. It is important to ensure that people with a positive</p> | Standards document updated.   |

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|                                     | screening test, meaning that blood was present, are offered the opportunity to be screened for bowel cancer by undergoing a colonoscopy.”   |   |
| Standard 2 – Reference comment      |   |   |
| 17                                  | Add “Jepson R, Clegg A, Forbes C, Lewis R, Sowden A, Kleijnen J. The determinants of screening uptake and interventions for increasing uptake: a systematic review. Health Technology Assessment.2000;4(14):1-133.” as a reference.   | Standards document updated.   |
| Standard 2 - Criterion 2.3 comment  |   |   |
| 18                                  | Please could you state how long this “episode” is kept open?  | No need to specify this as it is not relevant.                                      |
| Standard 2 - Criterion 2.4 comments |   |   |
| 19                                  | 2.4 ? re word (statement doesn't read well)<br><br>"People can opt out for an indefinite period. If they opt out, they must sign a disclaimer form which includes information about reinstatement. Their GP will be informed."  | Standards document updated.   |
| 20                                  | There should be an additional criteria following from 2.4 stating:<br><br>Eligible people aged between 5- -74 can ask for screening at any time if it is more than 2 years since a valid result was recorded.   | Standards document updated.   |
| Standard 2 - Criterion 2.5 comments |   |   |
| 21                                  | It should be: People who are over the age of 74 ...   | People are called right up to they're 74 years and 364 days old.                    |
| 22                                  | Criterion 2.5 suggested change:<br><br>People who are over the age of 75 years can request screening at two year intervals in line with the bowel screening pathway if it is more than 2 years since a valid result was recorded.   | Standards document updated.   |
| 23                                  | The College is in general agreement with these points, however would appreciate clarification on 2.5 (giving people the option to continue screening beyond the age of 75). If there is continued benefit over 75 years, it should be offered routinely, unless a decision has been made nationally to restrict screening to under-75s on the basis of limited resources. | There is no evidence to support the continuation of screening beyond the age of 74. |

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| Standard 2 – Criterion 2.6 comment |   |   |
| 24                                 | <p>Criterion 2.6 should read:</p> <p>NHS Boards and GPs receive prompt information by electronic message on people with a positive screening test result.</p>   | Standards document updated.   |
| Standard 2 – Criterion 2.7 comment |   |   |
| 25                                 | <p>New Criterion 2.7</p> <p>GPs are informed by electronic message of all outcomes of the screening test. (Non responder, Negative, Positive, Double spoiled and out, No Colon reported and requiring confirmation, participant has permanently excluded themselves).</p>   | Standards document updated.   |
| Standard 3 – General comments      |   |   |
| 26                                 | <p>On the list of people who are targeted for uptake there is no mention of physical disability. Some people in this group may be willing to participate, but find it physically impossible to undertake the test themselves as basic sight and dexterity are diminished. It may be that extra help needs to be considered for this people group.</p>   | Standards document updated.   |
| 27                                 | <p>I've had good feedback from the television advert. More visual wall charts/pamphlets in GP surgeries. Uptake from 'word of mouth', from people who have had positive results with immediate family and friends.</p>  | The project group noted the comment.                                  |
| 28                                 | <p>To reduce variation in test uptake related to ethnicity, gender, age and deprivation the standard should include adding to or modifying the existing correspondence to make it more relevant to these groups. This may take the form of an additional information leaflet to be sent with screening invitations, a personalised endorsement statement from the patient's GP practice or a modified reminder letter that includes additional text encouraging non-responders to return their screening kit.</p> | This comment is outwith the remit of Healthcare Improvement Scotland. |
| 29                                 | <p>It is well known that this population screening service is not set up to enable all individuals to participate if they have certain known characteristics and it is important to acknowledge this in our standards.</p> <p>For example, people who are registered blind or who have manual dexterity difficulties cannot take part in bowel screening. This has often been pointed out by callers to the Helpline as a serious gap in our service.</p>   | Standards document updated.   |

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|        | <p>It is therefore important that we explain in our standards what we expect to be in place to manage the health of these people who cannot access this population screening service for bowel cancer.</p> <p>This is something that is explained to callers to the Helpline who cannot take their own samples we explain that for instance “your GP will be aware that you cannot see blood in the bowel motion and will be checking your health accordingly and you should report symptoms to your GP”. Callers will often respond that they cannot see their stool and therefore cannot see blood in the stool.</p> <p>We would expect the GP to be managing the care differently and tailored to that person’s circumstances. For instance; If a registered blind patient reports a change in bowel habit but cannot tell if blood is being passed then the GP, knowing that bowel screening was not suitable, might review this patient more frequently or differently.</p> <p>Can we have an additional criteria to explain to the public/service users how a GP is expected to manage care in these circumstances? Something like this as below:</p> <p>3.3 NHS boards should guide GPs to manage care for those patients who are unable to access bowel screening.</p> |  |
| 30     | <p>Not sure if this is the right place to feed this back, and realise I have just missed the closing date, however I would like to highlight one of the biggest obstacles to increasing uptake of the bowel screening programme, which is FAILURE TO PROVIDE GPS WITH ADDITIONAL KITS THAT THEY CAN ISSUE.</p> <p>This is particularly relevant in deprived areas, where patients are not proactive about their health. When we see patients, we have some ability to persuade them to take the test, particularly if they have any related symptoms, however the fact that we cannot reissue them with a kit means that the opportunity is missed. To expect the patient to then go home and phone up for a new kit is to entirely misunderstand the mode of thinking of patients in deprived areas.</p> <p>Another point is that when reminder letters are sent out, a second kit is not sent, again putting the onus on the patient to phone up and order a new kit. This, again, is not going to be effective in deprived areas. I</p>   | <p>This is part of a pilot being run nationally at the moment. No change to the standards document needed.</p> |

| ID no.                                  | Consultation comment   | Project group response   |
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|   | appreciate that you may not wish to send out new kits to all non-responders, but you should consider doing so to those with postcodes in areas of deprivation.   |  |
| Standard 3 – Standard Statement comment |  |  |
| 31                                      | Statement should read: Scottish Bowel Screening Service .....or just bowel screening.  | Standards document updated.  |
| Standard 3 – Rationale comments         |  |  |
| 32                                      | Is the final semi-colon grammatically correct?   | Standards document updated.  |
| 33                                      | Should have commas and not semi colons during the list of hard to reach groups and no comma before 'and people in long-stay....  | Standards document updated.  |
| Standard 3 – Criterion 3.1 comment      |  |  |
| 34                                      | It is interesting to note that the group have not changed the 60% uptake standard since 2007 but the highlighting in bold and underscore that it applies to both women and men is to be welcomed. Nevertheless, perhaps '60% of people' would suffice. If a sex distinction is really required '60% of both and men and women complete the test' conveys the meaning.  | Project group noted that as more women take the test then an overall percentage may be skewed. |
| Standard 3 – Criterion 3.2 comment      |  |  |
| 35                                      | The following comment has been made: At 3.2 the requirement to maximise uptake may be a difficult standard to measure – is this ensuring the invitation is sent out in multiple formats or is it a responsibility for the NHS boards to offer near person support – and linking back to 2.3 on what grounds do we make assessment that non participation is due to disability other factors or actual participant choice?'<br><br>Looking at the previous standards and what is now in the latest version I wonder if some meaning has been lost by merging the standards together.<br><br>Because of the need to ensure participants are informed about the risks and benefits of screening and the need for informed choice, it is debatable whether 60% completion should be included as a criterion. | Standards document updated.  |

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| ID no.                              | Consultation comment  | Project group response  |
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| Standard 4 – General comments       |   |   |
| 36                                  | People are squeamish about how to handle the stool and more information on how to carry out the procedure   | Wording directing people to NHS Inform and the Bowel Screening Centre has been added. |
| 37                                  | Comments of why 2nd test is smaller.  | Wording directing people to NHS Inform and the Bowel Screening Centre has been added. |
| 38                                  | <ul style="list-style-type: none"> <li>• how to access other languages, easy to read and other formats.</li> </ul> <p>Would this perhaps read better as; how to access alternative languages or reading formats?</p> <p>Is a helpline still available for participants to call in for advice? If so, is this going to be detailed in the standards as was previously?</p>   | Standards document updated.   |
| 39                                  | Information should be provided in a format relevant to all target groups. This will require leaflets specifically designed for certain ethnic groups and also in formats that are accessible to those with differing needs. This should include straight forward language, large print, brail and others.   | This comment is outwith the remit of Healthcare Improvement Scotland.                 |
| Standard 4 – Criterion 4.1 comments |   |   |
| 40                                  | <p>Add these bullet points:</p> <ul style="list-style-type: none"> <li>• that the test kit is designed to detect blood in the stool and not cancer</li> <li>• that the colonoscopy is offered to those at higher risk of bowel cancer because they have blood in the stool</li> </ul>   | Standards document updated.   |
| 41                                  | Provide a separate bullet point for... how to return it to the screening centre   | Standards document updated.   |
| 42                                  | 4.1 - this has not changed in any major way from the 2007 version we believe there should be an additional bullet point between points 4 and 5 as listed. A large number of people are worried about the prospect of colonoscopy - from what they have heard from others, what they have read about (especially the internet), and from their own preconceptions. The bullet points in this section relate to the information participants are to be sent out but omit any details about pre-assessment hence the reader may well think that the next step after a positive screening test is a | Standards document updated.   |

| ID no.                                  | Consultation comment  | Project group response   |
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|   | <p>colonoscopy appointment and bowel prep dropping through the door. If patients were to be reassured at this early stage that if his/her test is positive he/she will be invited to take part in either a face-to-face or telephone consultation with a health care professional to decide on the best way forward, participation rates may be higher.</p> |  |
| Standard 5 – General comment            |   |  |
| 43                                      | <ul style="list-style-type: none"> <li>• We believe that the criteria under this standard apply to the Scottish Bowel Screening Centre rather than NHS Boards.</li> <li>• It may be helpful to explicitly state this to avoid potential confusion and uncertainty.</li> </ul>   | Project group disagreed so no changes made to the standards document.                      |
| Standard 5 – Criterion 5.1 comment      |   |  |
| 44                                      | <p>Perhaps:</p> <p>Identifiable screening test received by the laboratory (i.e. with the person/s name, community index etc), will be sent an outcome letter within 10 working days.</p>  | Project group decided original wording was fine.   |
| Standard 6 – General comment            |   |  |
| 45                                      | <ul style="list-style-type: none"> <li>• We believe that the criteria under this standard apply to the Scottish Bowel Screening Centre rather than NHS Boards.</li> <li>• It may be helpful to explicitly state this to avoid potential confusion and uncertainty.</li> </ul>   | Project group disagreed so no changes made to the standards document.                      |
| Standard 6 – Standard Statement comment |   |  |
| 46                                      | Should be analysis not analyses.  | Standards document updated.  |
| Standard 6 – Criterion 6.1 comments     |   |  |
| 47                                      | Organisation (s not z), Standardisation (s not z).  | The reason for the 'z' is that it is the name of an organisation.                          |
| 48                                      | 6.1: we note the American style spelling which is distinct from the convention used on the same page in the headline standard.  | Standards document updated.  |
| Standard 7 – General comments           |   |  |
| 49                                      | Is pre-assessment necessary!! People know a positive result, they want a colonoscopy as soon as possible, because you get immediate assessment and feedback.  | Project disagreed as pre-assessment determines whether the patient is fit for colonoscopy. |

| ID no.                                  | Consultation comment  | Project group response   |
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| 50                                      | Time of treatment, surgery and post op treatment is very important.   | Noted.   |
| 51                                      | Should there be guidance on checking patients bloods prior to prescribing bowel prep as per BSG guidelines? Many patients on ACEis, ARBs, NSAIDs and diuretics do not have up-to-date bloods (within last 3 months) to check renal function. To maximise safety for these patients bloods need to be requested and delays the target times.   | This comment is outwith the remit of Healthcare Improvement Scotland.                                      |
| 52                                      | <p>Standard 7</p> <p>Demonstrate safe management of patients not proceeding to colonoscopy</p> <p>“Most patients not proceeding to colonoscopy are reviewed in SOPD re fitness. A clinic letter is generated to the GP. Is this adequate or is this something that should be audited? If patient is unfit for colonoscopy is there expectation of arranging an alternative test .eg contrast CT/CT colonogrpahy etc.”</p> | This is for local determination, therefore outwith Healthcare Improvement Scotland's remit.                |
| 53                                      | Guidance should be provided on how clinicians should respond to patients who refuse colonoscopy. This should include alternative investigative options and when they are to be offered.   | Project group disagreed so no changes made to the standards document.                                      |
| Standard 7 – Standard Statement comment |   |  |
| 54                                      | People .....are offered a timely .....  | Standards document updated.  |
| Standard 7 – Evidence comment           |   |  |
| 55                                      | Job descriptions won't evidence either 7.2 or 7.3. The SOP would be enough – it should describe who carries out pre-assessment  | The project group took the decision to keep this in.   |
| Standard 7 – Criterion 7.1 comments     |   |  |
| 56                                      | Decide on punctuation at end of list or not.  | The original wording is in Healthcare Improvement Scotland's house style. No change to standards document. |
| 57                                      | <p>Suggested change to 7.1 People with a positive screening test result are offered a pre-colonoscopy assessment which will include:</p> <ul style="list-style-type: none"> <li>• An explanation of the colonoscopy process</li> <li>• The possible risks of bleeding or perforation</li> </ul>   | Standards document updated.  |

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|                                     | <ul style="list-style-type: none"> <li>• and outcomes (normal, polyps, cancer)</li> <li>• written information explaining the above, and</li> <li>• the opportunity to discuss any concerns</li> </ul>  |  |
| Standard 7 – Criterion 7.4 comments |  |  |
| 58                                  | The College is in general agreement with this standard. However we would appreciate clarification on 7.4, “safe management of patients with positive screening test who do not have a colonoscopy” as to how this would differ from informing the patient and GP (as per 7.5).   | Criterion 7.4 removed from standards document. |
| 59                                  | 7:4: we would suggest there ought to be clarity about what is expected or required of 'safe management' when a patient tests positive and (for whatever reason) does not undergo a colonoscopy. It would be useful to cite an evidence base.   | Criterion 7.4 removed from standards document. |
| 60                                  | Criterion 7.4: We believe it would be helpful to define what would constitute 'safe management'.   | Criterion 7.4 removed from standards document. |
| Standard 7 – Criterion 7.5 comment  |  |  |
| 61                                  | <p>Suggested change:</p> <p>NHS boards are responsible to inform GPs of all outcomes of colonoscopy including those who do not go on to have colonoscopy.</p> <p>GPs are informed by electronic message of all outcomes of the screening test including those referred for colonoscopy.</p>  | Standards document updated.                    |
| Standard 7 – Criterion 7.6 comment  |  |  |
| 62                                  | <p>Date offered for colonoscopy is not reported within the national key performance indicator report produced by ISD – instead, the proportion of patients who underwent colonoscopy within specified time periods following referral to their NHS Board of residence is provided.</p> <p>In light of this, we would suggest that this criterion be replaced by one relating to the number of days between referral &amp; colonoscopy being undertaken (with the standard reflecting / allowing for patient choice).</p> | Noted.   |

| ID no.                        | Consultation comment  | Project group response  |
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| Standard 8 – General comments |   |   |
| 63                            | I think it should go into the standards that for those who have a failed colonoscopy they should have a CT colonography which mirrors the English standards. However this is not something we can provide in Fv even though we have trained radiologists because of lack of support for the business case from management - if it went in the standards then this would help in getting this valuable service in place - especially given we have the trained staff on board already. | Noted.  |
| 64                            | It is specified that screening colonoscopy should be carried out by an endoscopist who can meet the quality criteria mentioned, but we believe an endoscopist who has passed the JAG Colonoscopy Accreditation Process ( <a href="https://www.jagaccreditation.org/">https://www.jagaccreditation.org/</a> ) would also be a suitable operator.   | Standards document updated.   |
| 65                            | Appreciation of quick assessment during colonoscopy and discussion of options and timeframes immediately after.   | Standards document updated.   |
| 66                            | This has rather glossed over the alternative test should colonoscopy be incomplete or refused.  | Project group agreed this comment is already covered by what is in the standards document.  |
| 67                            | CT colonoscopy should be the alternative of choice and barium enema consigned to history.   | Standards document updated.   |
| 68                            | Of more importance is the technique of CT colonoscopy chosen  | Noted.  |
| 69                            | Ie +/- IV contrast and the use of faecal tagging.   | This comment is outwith the remit of Healthcare Improvement Scotland.                       |
| 70                            | Accreditation of those reporting screening CTs also needs addressed   | Project group agreed this comment is already covered by what is in the standards document.  |
| 71                            | If colonoscopy complete to caecum but deemed a failed colonoscopy due to poor prep. Should the repeat colonoscopy be on another bowel screening list or is it ok for this to be carried out on a regular list.  | This is for local determination, therefore outwith Healthcare Improvement Scotland's remit. |
| 72                            | The reference to barium enema should be phased out and replaced by CT colonoscopy as this is more   | Standards document updated.   |

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|                                     | effective than the current radiological standard of barium enema at finding bowel cancers and precancerous polyps.  |   |
| Standard 8 – Standard Title comment |   |   |
| 73                                  | The fact that ‘Standard 8- Colonoscopy’ doesn’t mention radiological methods is a significant omission.   | Project group disagreed so no changes made to the standards document. |
| Standard 8 – Reference comment      |   |   |
| 74                                  | <p>CT vs Barium Enema:</p> <p>Computed tomographic colonography versus barium enema for diagnosis of colorectal cancer or large polyps in symptomatic patients (SIGGAR): a multicentre randomised trial: The Lancet, Volume 381, Issue 9873, Pages 1185 - 1193, 6 April 2013</p>  | Standards document updated.   |
| Standard 8 – Evidence comment       |   |   |
| 75                                  | There is no certificate that demonstrates colonoscopy performance. Evidence would be 12 months audit of individual screening colonoscopists. If Bowel Screening Assessment (driving test) is included then the evidence would be ‘evidence of attendance’.  | Standards document updated.   |
| Standard 8 – Criterion 8.2 comments |   |   |
| 76                                  | <p>1. Does this statement apply to only colonoscopies carried out in the bowel screening programme or in the colonocipists complete work load?</p> <p>2. If complete work load 35%adenoma detection rate is ambitions.</p>  | Standards document updated.   |
| 77                                  | Did we not have a statement here about Bowel Screening Assessment (driving test)?   | Standards document updated.   |
| 78                                  | I am concerned about criterion 8.2. Here we are asking for colonoscopy to be carried out by a colonoscopist who can show at least 90% colonoscopy completion, 35% adenoma detection rate and a 6 minute withdrawal time for diagnostic colonoscopy in continuous audit of screening colonoscopy. While this is an excellent aspiration if it is interpreted as colonoscopists who have demonstrated these criteria it will debar a number of competent colonoscopists, either because they have not done enough screening colonoscopies to demonstrate these figures or because they do not have access to the data that they need to demonstrate | Standards document updated.   |

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|        | <p>it. I understand that it could be argued that these are colonoscopists who have not necessarily demonstrated these achievements but are in a position to measure them sometime in the future. I do not think that this is rigorous enough and I should be much happier to see it worded as follows:<br/> “Colonoscopies carried out by a colonoscopist who can demonstrate at least 90% colonoscopy completion, 35% adenomas detection rate and a 6 minute withdrawal time for diagnostic colonoscopy and continuous audit of screening colonoscopy or who has passed the JAG Colonoscopy Driving Test (reference). We have an opportunity here to really mandate high quality colonoscopy for the screening programme but the criterion has to be meaningful and realistic.</p>  |  |
| 79     | <p>The colonoscopy completion rate should be specified as ‘unadjusted’</p> <p>The withdrawal time is a new feature – does this apply to all colonoscopies or just the negative complete colonoscopies as in the English screening programme.</p> <p>I note that the requirement for a colonoscopist to attend a JAG course has been removed. It would be important to have some form of accreditation for screening colonoscopists in Scotland to ensure that a quality standard is being met, especially as the units themselves will not require accreditation. It is unclear from the wording if the colonoscopist requirements refer to an individual qualifying to become a screening colonoscopist or to ongoing quality audit for those already undertaking screening.</p> <p>There is probably a good case for specifying a minimum number of colonoscopies per year.</p> <p>As well as the ADR, perhaps the cancer detection rate should also be monitored.</p> | <p>Standards document updated. Comments noted, but the project group agreed that the cancer detection rates are insufficiently sensitive to use.</p> |
| 80     | <p>I was interested to read the new standards document which looks good. Previous standards to guide on selection of endoscopists to carry out screening required operators to have a 90% completion rate and to have been on a skills course. You have expanded this to include a 35% adenoma detection and a 6 minute withdrawal time but no courses are mentioned. Does this mean that the group felt that a course was no longer a requirement or is this an omission? This would perhaps be an opportunity to re-align Scotland</p>   | <p>Standards document updated.</p>   |

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|        | with England and require screening colonoscopists to take the driving test?  |   |
| 81     | <p>The College is generally in agreement with this standard, however 8.2 specifies three performance markers for colonoscopists which are rightly set at a high level but most of these markers are not routinely audited nor does the infrastructure currently exist to provide continuous audit.</p> <p>There would be resource implications due to the need to fund such audit and this should be taken into account.</p>   | Project group agreed to keep these markers in place as it was decided that these markers ensure a high quality service. The system can be adjusted with minimal effort. |
| 82     | <p>The standard for colonoscopy is the greatest change evident in the revised standards and is to be welcomed i.e. it lists adenoma detection rate and extraction times as quality measures. For too long colonoscopy has been seen as a challenge to reach the caecum, in some instances at the expense of diagnostic quality. Small adenomas are more likely to be detected during the withdrawal phase of colonoscopy hence the importance of extraction time and this is all to the benefit of quality. There will, however, be significant implications for some Boards - extraction time is not routinely recorded by endoscopy teams and some hospitals running screening lists of 6 and sometimes more patients. Given the positive predictive value of a positive bowel screening test (i.e. often multiple adenomas to deal with), the need to spend time with these patients before and after 'scoping, and a standard that prescribes extraction times, the number of patients on some of these lists will need to be addressed.</p> | Noted. Withdrawal time is monitored and there are systems to do this.   |
| 83     | <p>The 6 minute withdrawal time for diagnostic scopes is reasonable but difficult to measure as would have to select out only diagnostic and not therapeutic screening scopes, let alone the difficulty in actually measuring the time itself.</p>   | Noted.  |
| 84     | <p>The only comment here is that the ENDORSE Programme is underway. Although there is no central funding available for JAG accreditation the chair of the group is writing to Chief Executives (December 2014) to sell the benefits of JAG in the hope that they will agree to fund the accreditation.</p> <p>The caveat would be that some future proofing may be required here should JAG accreditation be Sought / achieved by Boards.</p>  | This comment is outwith the remit of Healthcare Improvement Scotland.   |

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| Standard 8 – Criterion 8.5 comments                       |   |   |
| 85  | <p>Can you clarify whether the appointment date for enema or CT is within 14 days?</p> <p>Or, should the patient be informed of the new appointment date within 14 days? Bearing in mind the new appointment may be 4-weeks away.</p>   | Standards document updated.   |
| 86  | It has been raised that bowel preparation is mentioned here but nowhere else in the standards. It has been suggested that a statement on best practice for bowel prep may be required as there has been variations in practice in recent years.   | This comment is outwith the remit of Healthcare Improvement Scotland. |
| 87, 88, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 103, 104, | 8.5 – should read “If bowel preparation has not been effective”   | Standards document updated.   |
| 89  | Suggest re word statement - the patient is offered a date for either barium enema, computed tomography colonography or repeat colonoscopy within 14 working days  | Standards document updated.   |
| 100   | <p>I don't think 8.5 reflects the reality of radiological practice across most NHS Boards in Scotland.</p> <p>CT colonography is the radiological investigation of choice and very few centres perform regular barium enemas. In NHS Lothian, we now only perform a handful of barium enemas per annum (happy to provide exact data if necessary). The majority of CT colons performed on bowel screening patients have been identified at pre-assessment as being unsuitable for optical colonoscopy. This will be for a variety of reasons, often significant comorbidity or anticoagulation. We also have a proportion of patients who wish screening, but are not suitable for bowel cleansing – these are often offered a 'minimal preparation CT of colon'.</p> | Standards document updated.   |
| 101   | <p>8.5 if colonoscopy has failed due to poor bowel prep, then a barium enema/CTC will similarly provide a poor result. in this situation, a repeat colonoscopy with alternative/more aggressive bowel preparation would be usual clinical practice.</p> <p>For an incomplete colonoscopy for other reasons, the</p>   | Standards document updated.   |

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|   | current standard is CTC; barium enemas have been shown to be far inferior imaging modality.  |   |
| 102   | The date patient is offered is not recorded within ecase only the date in which the procedure is carried out- new fields would have to be added to ecase audit tool.   | This comment is outwith the remit of Healthcare Improvement Scotland. |
| 105   | The date patient is offered is not recorded within ecase, only the date on which the procedure is carried out. New fields would have to be added to the ecase audit tool.  | This comment is outwith the remit of Healthcare Improvement Scotland. |
| <b>Standard 8 – Criteria 8.5 and 8.6 comments</b> |  |   |
| 106   | <p>Criteria 8.5 and 8.6: We would suggest that barium enema should be removed and that either repeat colonoscopy or CT colonoscopy be offered as valid follow-up procedures.</p> <p>Related to this, we would suggest that consideration should be given to specifying the technique for CT colonoscopy (i.e. +/- IV contrast and the use of faecal tagging).</p>  | Standards document updated.   |
| 107   | Standard 8, paragraphs 8.5 and 8.6: it is frustrating to see any mention of barium enema in the context of bowel cancer screening. The SIGGAR I trial (Lancet, 2013) conclusively demonstrated the inferiority of barium enema to CT colonography in detection of colorectal cancer. Given that "obvious" cancer is not the only valid end point for the screening process, and that barium enema has been known for many years to have a very low sensitivity for the detection of colonic polyps, it is not acceptable to offer barium enema in a bowel cancer screening programme. The authors will be aware that NHS England's screening programme no longer permits barium enema as an alternative to colonoscopy. There is anecdotal evidence that many NHS departments of radiology no longer perform barium enema - it is an obsolete examination. | Standards document updated.   |
| 108   | <p>8.5 and 8.6</p> <p>Barium enema is an outdated and obsolete examination in this context. It is inaccurate, unpleasant and ineffective. It should not be used. We would recommend that only repeat colonoscopy or CT colonography are listed here.</p>   | Standards document updated.   |
| 109   | We are supportive of the term barium enema being removed from the standards in light that the expert   | Standards document updated.   |

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|                                     | advice is that CTC should be used.  |   |
| Standard 8 – Criterion 8.6 comments |   |   |
| 110                                 | <p>If barium enema is still to be included, it should be mentioned after CT colonography. Screening CT colonograms should always be reviewed/reported by a consultant radiologist, competent in CT colonography (some centres will also have an initial read of colonic findings only by a suitably trained radiographer). For barium enema patients, I am unaware of any centres who would issue a report from a radiographer alone for +ve screeners.</p>   | Standards document updated.   |
| 111                                 | Is barium enema not now a historical examination?   | Standards document updated.   |
| 112                                 | <p>Regarding section 8 of the Draft guidelines for bowel screening.</p> <p>This essentially states that Ba enema may be performed if incomplete colonoscopy. This mirrors the European guidelines (which are now 3 years old). It contradicts the English screening protocol, and statements made this year by a combined document from the Royal College of Radiologists and BSGAR which clearly state that Ba enema should not be used as 2nd line.</p> <p>We're (Forth Valley) struggling with this. We are currently putting together a business case for CT colonography. Release of guidelines that state that Ba enema is an acceptable 2nd line will be a clear message to Scottish Health boards to NOT invest in CT colonography. It potentially creates a weaker screening system compared with England.</p> <p>I'm not sure what the answer is. But another point to make is that there are strict guidelines for training to report CT colonography. If we are to utilise Ba enema instead then it is imperative that we have the same set of strict guidelines for fluoroscopic examinations (double reading, QA etc).</p> <p>I hope these comments are useful and thanks to the group for working on these guidelines.</p> | Standards document updated.   |
| 113                                 | The only date recorded is the date the procedure is carried out not the date of authorisation-further fields would be required to be added to audit   | This comment is outwith the remit of Healthcare Improvement Scotland. |
| 114                                 | 8.6 – the outcome should be notified to the GP within 7 working days of the examination   | Standards document updated.   |

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| 115                                 | The only date recorded is the date the procedure is carried out, not the date of authorisation. Further fields would require to be added to the audit.  | This comment is outwith the remit of Healthcare Improvement Scotland.                                 |
| Standard 9 – General comments       |   |   |
| 116                                 | The College is generally in agreement with this standard; however notes no time targets have been set (as they have for all other steps in the process). At present there is often a delay in the reporting of pathology specimens, and setting a specific target here would be an opportunity to improve standards.  | Noted. It is not possible to specify a time target owing to the variable time for different specimen. |
| 117                                 | Is there a time scale in which the histology report should be authorised?   | Noted. It is not possible to specify a time target owing to the variable time for different specimen. |
| Standard 9 – Criterion 9.1 comment  |   |   |
| 118                                 | Guidelines should have a capital G.   | Standards document updated.   |
| Standard 9 – Criterion 9.2 comments |   |   |
| 119                                 | <p>Cellular pathology reporting should be of a high standard and if the intention is to use the RCPATH colorectal dataset to audit general colorectal reporting as a surrogate marker of the quality of Bowel Screening reporting we believe this should be clearly stated.</p> <p>The RCPATH audit figures (both in 2007 and the 2014 dataset) are specifically for non-screening and treatment naïve cases. We appreciate that the RCPATH dataset audit figures (from the 2007 dataset) have been used previously in Scotland to gauge colorectal histology reporting practice in the neo-adjuvant treated, screening and non-screening resection cases (under the guise of Screening Program Quality Assurance).</p> <p>As we don't have any standards specifically for a screening population, we can either set new standards or use the RCPATH standards. If we use the RCPATH standards we believe that there should be a prominent caveat that they are not standards for a screening population and some boards will not meet these standards on their bowel screening cases alone, given the variation in practice of pre-operative therapy for rectal tumours.</p> <p>If we are to set new specific Scottish Screening standards, a sensible approach would be to just</p> | Standards document updated.   |

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|                                     | <p>include lymph node number (in non neo-adjuvant cases) as this is a good marker of the histopathology handling of the specimen. The other two RCPATH parameters depend on the extent of tumour within the specimen which in a screening population should be of lower 'stage' than that of the symptomatic population that the RCPATH numbers are based on.</p> <p>The new dataset also states that venous invasion (and greatest extent of it) is recorded – not just extramural invasion. It seems strange to have standards for bowel screening that are based on standards that specifically exclude screening cases.</p> <p>Would the wording be better as:- "9.2: Departments reporting bowel screening resection cases should provide a high quality service and be able to show their General Colorectal Reporting practice is in line with the audit criteria recommended by the Royal College of Pathologists standards (including lymph node number, serosal involvement and venous invasion)."</p> |   |
| 120                                 | <p>Resected cancers pathology are not recorded within the bowel screening.</p> <p>They are recorded in the colorectal audit, only the TNM is recorded, again further fields would have to be added to the bowel screening case.</p>  | This comment is outwith the remit of Healthcare Improvement Scotland. |
| Standard 9 – Criterion 9.3 comments |  |   |
| 121                                 | Can the reference to Procurement, Commissioning and Facilities Strategic Business Unit be Reworded in that they 'commission' the scheme and not run it and change PCF SBU to National Specialist and Screening Directorate.  | Standards document updated.   |
| 122                                 | 9:3: There is a feeling that the language of this section could be more crisp as compared with the rest of the standards. Not a major point.   | Project group disagreed so no changes made to the standards document. |
| Standard 9 – Criterion 9.4 comment  |  |   |
| 123                                 | ".....specimens fully participant in the UK bowel screening....."  | Standards document updated.   |



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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.



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