



Public Health
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NHS public health functions agreement 2019-20

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Bowel scope screening

NHS England and NHS Improvement



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Promoting equality and addressing health inequalities are at the heart of NHS England and NHS Improvement values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic and those who do not share it (as required under the Equality Act 2010); and
- Given due regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities (in accordance with the duties under sections 13G and 13N of the NHS Act 2006, as amended).

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1 Purpose of the screening programme

1.1 Purpose of the Specification

To ensure a consistent and equitable approach across England a common national service specification must be used to govern the provision and monitoring of bowel scope screening.

The purpose of the service specification is to outline the service and quality indicators expected by NHS England and NHS Improvement for the population for whom it is responsible, and which meets the policies, recommendations and standards of the NHS Bowel Cancer Screening Programme.

This specification is not designed to replicate, duplicate or supersede any relevant legislative provisions which may apply, e.g. of the Health and Social Care Act 2008 or the work undertaken by the Care Quality Commission. The specification will be reviewed and amended in line with any new guidance as quickly as possible.

This specification should be read in conjunction with the [bowel scope screening guidance](#)

1.2 The role of PHE Screening

Public Health England (PHE) advises the government and the NHS so England has safe, high quality screening programmes that reflect the best available evidence and the UK National Screening Committee recommendations. PHE also develops standards and provides specific services that help the local NHS implement and run screening services consistently across the country.

Providers should subscribe to the [PHE Screening blog](#) for the latest national news and updates. [National documentation and guidance](#) are published on GOV.UK.

1.3 Personal Informed Choice

All screening is an individual choice. The UK NSC has published [guidance for screening programmes in the 4 UK countries](#) to follow. Everyone must be given the opportunity to make an informed choice about whether or not to be screened. The decision should be based on an understanding of:

- why they are being offered screening
- what happens during the test
- the benefits and risks of screening
- the potential outcomes (including types of result, further tests and treatment)
- what happens to their screening records

If someone is provided with the above information about the programme and chooses not to attend screening, then this is a valid choice and must be respected.

Opting out

Services should respect the decision of any individual choosing to [opt out of screening](#), either on a single occasion or permanently. No pressure should be put on people to be screened and services should not require the individual to justify their decision.

1.4 Public Information

PHE Screening uses published best practice processes to develop public information

leaflets. It also works with NHS Digital to ensure that information on the [NHS.UK](https://www.nhs.uk) website for the public is accurate.

Providers must:

- use the public information leaflets from PHE Screening at all stages of the screening pathway
- involve PHE in the development of any local awareness campaigns
- not duplicate clinical information on local websites
- involve PHE if they want to move from providing printed leaflets to online sources of information

Using the leaflets provided by PHE ensures accurate messages about the risks and benefits of screening and any subsequent surveillance or treatment are provided. PHE Screening must be consulted and involved before developing any other supporting materials.

Providers must involve PHE in the development of local publicity campaigns to ensure accurate and consistent messaging, particularly around informed choice, and to access nationally- developed resources. For local awareness campaigns, local contact details must be used so that the national screening helpdesk is not over.

Local provider websites must not duplicate clinical information about screening but should be restricted to contact and logistical information. Links should be provided to the national information on NHS.UK (<http://www.nhs.uk/Livewell/Screening/Pages/screening.aspx> or the relevant programme page) and GOV.UK (<https://www.gov.uk/topic/population-screening-programmes> or the relevant programme page).

To support PHE Screening to carry out regular reviews of the national screening public information leaflets and online content, providers are encouraged to send PHE Screening the results of any local patient surveys which contain feedback on these national resources.

Ordering leaflets

Providers can order [leaflets developed by PHE Screening](#) for free for core screening purposes.

Leaflets are regularly updated so providers should not order more than 3 months' supply, or stockpile leaflets, as they could become out of date and need to be destroyed. Leaflets for non-core activities, such as local health promotion purposes, can be bought from the national print provider.

PHE can only provide one leaflet per person per screening episode. A screening episode is defined as an invitation (with any subsequent reminders) for a particular screening test. People who are referred for further assessment following a screen should get a single copy of the appropriate follow-up leaflet.

This means that duplicate copies should not be provided with reminder letters or if people lose or forget their leaflet. They should be signposted to electronic sources of information instead.

1.5 Addressing inequalities and ensuring equal access to screening

Screening is offered to all individuals within the eligible population. One of the objectives of the NHS Screening Programmes is to help reduce health inequalities.

Sharing personal information

Under the [2010 Equality Act](#), screening services are required to anticipate and prevent discrimination against people with learning disabilities.

The duty of care to share information can be as important as the duty to protect patient confidentiality. GPs and other health professionals should have the confidence to share relevant information with screening services in the best interests of their patients. For example, a GP may know that an individual with a learning disability requires accessible information about screening in easy read format or needs a longer than normal appointment slot.

See [NHS England's information sharing policy](#) for more detailed guidance.

PHE Screening's [privacy notice](#) has more information about how screening data is shared within the legal requirements, including those of the General Data Protection Regulation (GDPR).

Reasonable adjustments

Under the [2010 Equality Act](#), screening providers have a legal duty to make [reasonable adjustments](#) to make sure services are accessible to everybody.

Screening providers must follow the [Accessible Information Standard](#) by law. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read or understand with support, so they can communicate effectively with health and social care services.

As part of the Accessible Information Standard, screening providers must do 5 things.

1. Ask people if they have any information or communication needs and find out how to meet their needs.
2. Record those needs clearly and in a set way.
3. Highlight or flag the person's file or notes so it is clear that they have information or communication needs and how to meet those needs.
4. Share information about people's information and communication needs with other providers of NHS and adult social care, when they have consent or permission to do so.
5. Take steps to ensure that people receive information which they can access and understand and receive communication support if they need it.

National accessible information materials

PHE Screening has published national easy read versions of screening information leaflets and screening appointment letter templates.

Local screening providers should use these national materials when inviting individuals for screening who have been identified as needing information in an easy read format.

Large print and audio versions of standard information leaflets are also available to download from GOV.UK for people with sight loss.

Local screening providers should send any individual requests for hard copy Braille versions of PHE Screening leaflets to the [screening helpdesk](#).

1.6 Equality

Delivery of the screening programme contributes to reducing health inequalities and should include the following deliverables:

- screening should be delivered in a way which addresses local health inequalities, tailoring and targeting interventions when necessary
- a Health Equity Audit should be undertaken as part of both the commissioning and review of this screening programme, including equality characteristics, socio-economic factors and local vulnerable populations
- the service should be delivered in a culturally sensitive way to meet the needs of local diverse populations
- user involvement should include representation from service users with equality characteristics reflecting the local community including those with protected characteristics
- providers should exercise high levels of diligence when considering excluding people with protected characteristics in their population from the programme and follow equality, health inequality and screening guidance when making such decisions

The provider will demonstrate they have systems in place to address health inequalities and make sure there is equity of access to screening, subsequent diagnostic testing and outcomes. This will include, for example, how the services are designed to make sure that there are no obstacles to access on the grounds of the nine protected characteristics as defined in the Equality Act 2010.

The provider will have procedures in place to identify and support those persons who are in prison; those with mental health problems; those with learning disabilities, visual impairment, physical disabilities or communications difficulties. The provider will comply with safeguarding policies and good practice recommendations for such persons.

Providers are expected to meet the public-sector Equality Duty which means that public bodies must consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees <https://www.gov.uk/equality-act-2010-guidance>

It also requires that public bodies:

- have due regard to the need to eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

1.7 Education and training

PHE screening provides a variety of education and training for NHS screening staff. Evidence based, up-to-date e-learning resources, study days and courses can be accessed here <https://www.gov.uk/guidance/nhs-population-screening-education-and-training>

In addition, each screening programme will have specific guidance for the initial training and ongoing learning for screeners. This learning should be facilitated, supported and monitored by local screening providers. In line with professional regulations individuals have a responsibility to ensure their practice is up-to-date and evidence based. Local programmes can use the national programme training guidance and resources to support this.

2 NHS Outcomes Framework Domains and Indicators

2.1 This specification will meet the following domains in the NHS Outcomes Framework

Choose from the list of domains that can be found here: <https://digital.nhs.uk/data-and-information/publications/ci-hub/nhs-outcomes-framework#framework-domains>

Domain 1	Preventing people from dying prematurely	√
Domain 2	Enhancing quality of life for people with long-term conditions	√
Domain 3	Helping people to recover from episodes of ill health or following injury	X
Domain 4	Ensuring that people have a positive experience of care	√
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	√

3 Background

Bowel scope screening is an alternative and complementary to faecal occult blood (FOB) testing. Evidence shows that for men and women aged 55 - 64 who attend a one-off bowel scope screening test (in this document bowel scope screening refers to flexible sigmoidoscopy screening) mortality from bowel cancer in this age group can be reduced by 43% (31% on an invited population basis) and incidence can be reduced by 33% (23% on a population basis).

A randomised controlled trial funded by Cancer Research UK, the Medical Research Council and NHS Research and Development Leads took place in 14 UK centres, and evaluated screening for bowel cancer using flexible sigmoidoscopy screening between 55 and 64 years of age, removing small polyps and providing follow up colonoscopy for high risk polyps.

The UK National Screening Committee (UK NSC) reviewed the evidence, and in April 2011 concluded that screening for bowel cancer using flexible sigmoidoscopy meets [the UK NSC](#) criteria for a screening test. Bowel scope screening began being introduced into the programme in England in 2013.

In June 2018 there were further discussions at the UKNSC about the continued use of bowel scope screening in the programme. The UK NSC discussed and supported the suggestion that bowel scope is still to be offered where currently available and to consider decommissioning it once Faecal Immunochemical Testing (FIT) was available in England to 55yr old's.

This modality of screening is complementary to the existing faecal occult blood screening programme [service specification 26](#)

4 Scope

Aims and objectives of the service

The aim of the [bowel scope screening programme](#) is to offer a one-off flexible sigmoidoscopy to all men and women from aged 55+2 weeks to their 56th birthday and for people aged up to their 60th birthday - can self-refer. It will look for bowel cancer, remove small polyps and provide where appropriate follow-up colonoscopy.

The bowel scope screening programme is being rolled out across England by GP practice.

5 Exclusions

The criteria for exclusion from bowel scope screening are:

- if a person is not registered with a GP practice
- if a person is not resident in England
- registered with a GP practice that is not yet included to deliver bowel scope screening
- if the individual has undergone total removal of the large bowel
- has opted out of the bowel scope screening episode understanding that they will be invited to undertake FOBt once they become 60 years old
- has made an informed choice not to take part in bowel scope screening and FOBt or is clinically unsuitable to take part in bowel cancer screening (ceased from the bowel cancer screening programme). That is, has signed a request that no further contact be made by the NHS BCSP at any time unless the individual changes their decision

6 Criteria for bowel scope screening

To ensure the quality and safety of symptomatic bowel cancer services and the colonoscopy element of FOBt, Public Health England have set the following criteria for local screening centres wishing to expand or open a new bowel scope screening site. Bowel scope screening must be delivered as part of a service/programme that also delivers the FOBt service. These principles have been adopted by NHS England in commissioning the service

Providing the criteria below is met, an endoscopy unit may deliver only bowel scope screening, but they must be a satellite unit of a bowel cancer screening centre.

Bowel scope screening sites should have achieved:

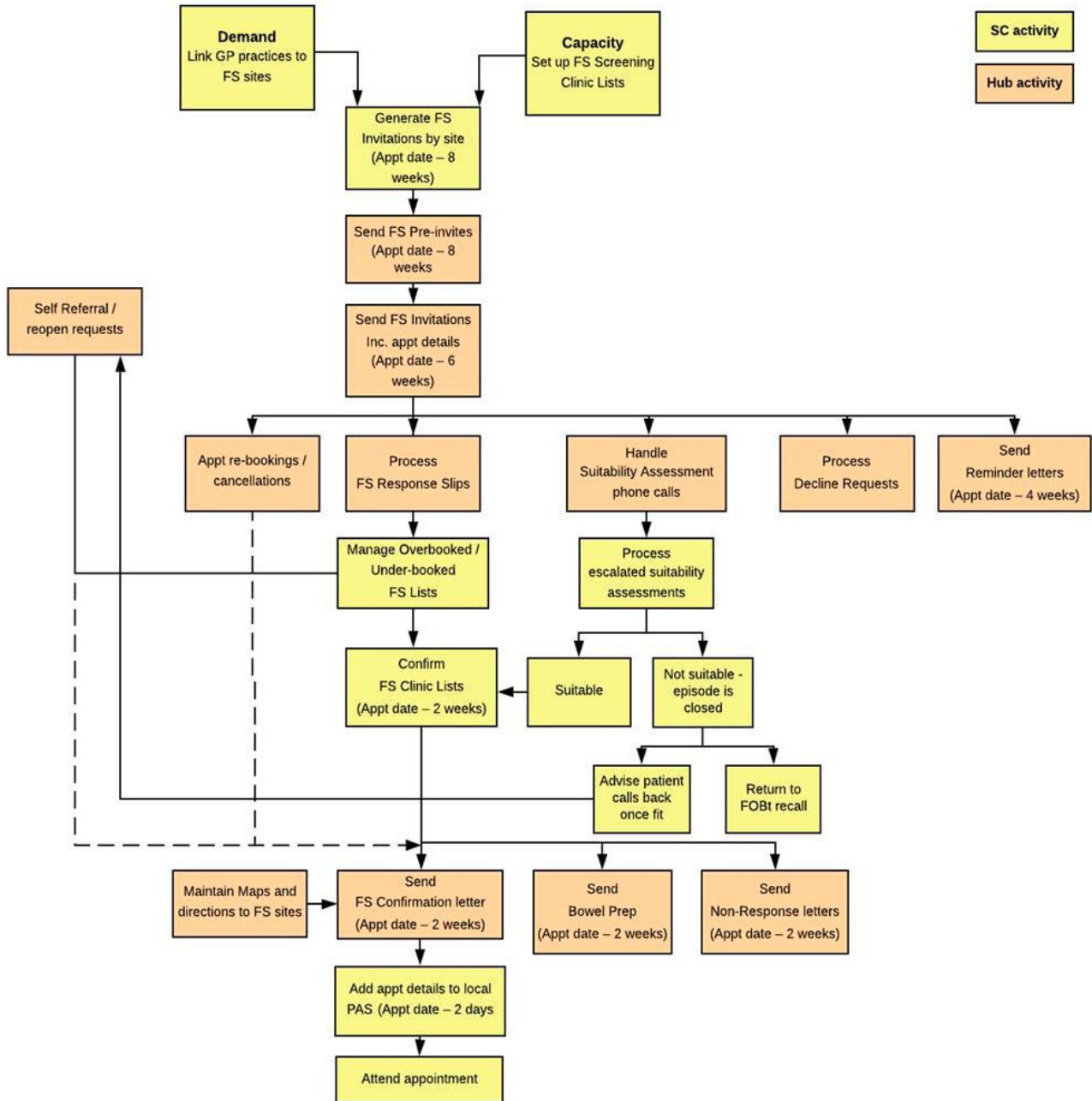
- meeting the [pathway standards](#) of the Bowel Cancer Screening Programme
- demonstrable sustainable endoscopy capacity for facilities and staff to deal with the increased workload with the expansion to incorporate bowel scope screening and continued growth in screening colonoscopic surveillance
- provision of CO2 for insufflation at all sites where bowel scope screening and screening colonoscopy is provided
- provision of entonox at all sites where bowel scope screening is provided
- maintenance of [Joint Advisory Group on GI Endoscopy \(JAG\)](#) annual accreditation at each endoscopy unit which offers bowel scope screening and screening colonoscopy
- sustained achievement of the operational standards for the relevant cancer waiting times should be delivered; however, the national context will be taken into consideration and where a site can evidence a recovery plan this will be considered acceptable
- histopathology samples should be processed in laboratories that manage FOBt specimens. Histopathologists who report BCSP specimens can report bowel scope specimens. To report BCSP specimens there is a requirement to participate in the BCSP External Quality Assurance (EQA) scheme. In addition, pathology laboratories which will report suspected bowel cancers arising in the programme should have a named BCSP lead pathologist identified, with whom other reporting pathologists can liaise
- sign off for expansion and roll out of the programme is required from the regional quality assurance team

7 Service description and care pathway

7.1 The screening pathway is divided into the following stages:

- Identification
- Invitation/inform
- Repeated cancellations/DNA's
- Self-referrers/opting in and Ceasing
- Test/procedure
- Diagnose/histology
- Results

7.2 Bowel scope pathway



7.3 Identification

The screening centre should have a demand and capacity plan to inform the roll out of bowel scope screening. The plan will identify which order each GP practice will join the roll out. The screening centre is responsible for maintaining the GP practice list (including updating of changes to GP practices and mergers) to make sure the Bowel Cancer Screening System (BCSS) remains accurate as the practice codes link within BCSS to identify the eligible population. Once the GP practice is linked to BCSS, participants are automatically selected to take part in bowel scope screening according to their age.

Providers should roll out bowel scope screening based upon the trajectory agreed with NHS England commissioners. A template to assist screening centres to plan [Demand and Capacity](#) is available.

7.4 Invitation and Inform

The screening centre will generate the invites for each screening site on a regular basis (daily or weekly). BCSS appoints participants into each slot automatically. The oldest participant will be appointed first.

Bowel scope screening will be delivered by the screening centres in conjunction with the screening programme hubs.

Pre-Invite - 8 weeks before the bowel scope appointment, prospective attendees are sent the pre-invite letter advising them about an imminent invitation to participate in bowel scope screening. There will also be a leaflet included to inform the participant's decision. Once the pre-invite has been sent out the participant can contact the hub to accept, change, or decline their appointment.

The hub staff can offer the participant an appointment up to 8 weeks in the future. Beyond that the participant will need to call back to arrange an appointment.

Invite – 6 weeks before the participants appointment BCSS automatically generates the invitation letter. This is printed by the Hub. This invitation will contain the time, date and location of the appointment and a response slip. If the participant chooses to take part, they must either return the provided response slip or ring the Hub to agree to take part.

Suitability - All potential participants are initially presumed suitable. Contraindications to bowel scope is in the leaflet sent out with the pre-invitation. Some participants may contact the hub with questions about their suitability to take part in bowel scope screening.

The invitation letter encourages participants who have imminent travel to contact the local screening centre to rebook for a later date post travel.

BCSS has a module to help guide hub staff in answering participant's questions. If the hub cannot resolve the query, they can escalate it to the local screening centre. This information is captured on BCSS to ensure that no participant is delayed in their pathway. All suitability queries must be resolved before the participant progresses to their appointment. This might require the appointment to be rescheduled.

If the participant makes contact about medication, the provider should record this in the suitability assessment data set.

Reminders - 4 weeks prior to the appointment, participants who have not contacted the hub to confirm their attendance at the bowel scope screening appointment are sent a reminder letter. This will often result in some of the individuals contacting the hub to accept, change or decline their appointment.

Management of appointments - from the time the pre-invite letters are sent to participants, the screening centre may have to change the bowel scope screening lists to achieve the optimal number of participants attending. This means that administrators may need to rearrange some appointments, remove empty appointment(s) and create new appointments.

2 weeks before the appointment date the screening centre will 'confirm' the bowel scope screening list on BCSS.

This action:

- confirms the screening centre will run the list;
- cancels any participants that have not responded to confirm their attendance; and
- produces the paperwork for the appointment for each participant who has already agreed to attend as follows:
 - a letter confirming the time, date and location of their appointment,
 - a map with the screening centre's contact details,
 - a participant specific consent form; and
 - as a separate mailing, the enema which comes from a centralised distribution centre

Participants who have not accepted their appointment will receive a letter informing them that it has been cancelled, their screening episode closed, and their GP informed. Closing of the screening episode enables BCSS to automatically recalculate the participants invitation date for FOBt screening.

If the participant does want to be screened, they can contact the hub who will provide an appointment if appropriate. Any unused slots on the bowel scope lists at 2 weeks before the appointment date can be used to bring other bowel scope participant forward, used as rebooking slots or used for the symptomatic service, to make sure capacity is not lost.

It is expected that providers will not confirm the list earlier in the pathway than 2 weeks before the appointment, to make sure participants have ample opportunity to respond. Once the list has been 'confirmed' it should not be cancelled. If the list is cancelled within the 2 weeks prior to the appointment, commissioners and SQAS must be informed.

The screening centre may choose to contact participants prior to their bowel scope appointment to provide additional information, reassurance and confirm attendance.

7.5 Repeated cancellations or DNA's

Repeated cancellations and Do Not Attends (DNAs) are a very costly waste of resource within the NHS and so it is important for providers to have a focused plan of action to proactively manage them.

Cancellations

Participants have the right to cancel their appointment ahead of the appointment time, if they are unable to attend. It is considered good practice to agree a date for another appointment at the time of the cancellation where possible. If it is not possible to arrange at the time of cancellation, another appointment should be provided as soon as possible.

Where a participant cancels a subsequent appointment (cancels their 2nd appointment), it will be necessary for a member of the team to telephone or write to the participant to

explain that no further appointments will be offered unless there are extreme unforeseen circumstances (this is at the discretion of the screening centre). The screening centre is responsible for informing the participants GP and closing the screening episode on BCSS. If the participant does want to be screened, they can contact the hub who will provide an appointment if appropriate. Closing of the screening episode enables BCSS to automatically recalculate the participants invitation date for FOBt screening.

DNA's

If the person does not attend their bowel scope screening appointment, the screening centre will close the episode on BCSS which in turn will send the participant a letter and a copy to their GP. If the participant does want to be screened, they can contact the hub who will provide an appointment if appropriate.

7.6 Self-referrers/Opting in/ Permanently opting out (ceasing)

Self-referrers/Opting in

Individuals who are aged between 55 +2 months and their 60th birthday (who have not been selected for FOBt) and are registered with a GP practice that has been linked to BCSS to deliver bowel scope screening, can self-refer. The potential participant can contact the hub who will arrange an appointment no less than 5 days in the future. This is to enable time for the appropriate correspondence to be delivered and the enema to be posted by the enema supplier. If the appointment is within 5 days, the hub needs to contact the screening centre to notify them that the participant will require an enema in the department, using the local hospital enema of choice.

Permanently opting out (ceasing)

When a participant is clinically unsuitable for bowel scope screening and FOBt, they can be permanently opted out (ceased) from the programme. This information should be clarified with the participants GP or Consultant in writing. This is to ensure there is no misunderstanding and to ensure that they are permanently not going to be eligible to partake in any part of the programme in the future, due to their medical situation.

When a participant makes an informed choice not to take part in bowel scope screening, it needs to be made clear to the participant that they will still receive an invitation to partake in FOBt screening when they become eligible. This information needs to be captured in a written format. If the participant is adamant they do not wish to have any future contact with the bowel cancer screening programme, and does not wish to receive an invitation to FOBt screening, a form needs to be signed or written confirmation from the participant requesting that no further contact be made by the NHS BCSP at any time. It should be made clear that they are able to change their decision at any time in the future to opt back into the programme.

Permanently opting out (ceasing) a participant that lacks capacity to make an informed choice or consent, requires the appropriate documentation to be completed and where necessary a best interest meeting should be held.

An annual audit of people permanently opted out (ceased) from the NHSBCSP needs to be carried out by the screening hubs.

7.7 Test/Procedure

Bowel scope screening data collection, including bowel scope screening attendance, is the responsibility of the screening team. A Specialist Screening Practitioner (SSP) or Screening Practitioner (SP) or Assistant Screening Practitioner (ASP) will be required for all procedures and to enter clinical information live in the procedure room to complete

the procedure data set. If the member of the screening team is an ASP working in the procedure room, there must be an SSP on-site to provide support and assistance on request.

Attendance for bowel scope screening will require the participant to be added to the local hospital patient administration system (PAS). This is required to make sure that bowel scope screening participants are not included in hospital symptomatic activity.

The SSP or SP or ASP or clinical member from the endoscopy unit will conduct an assessment to verify the individual's health status and suitability for the procedure. At this time the participant needs to be asked if they are taking blood thinning medication (not Aspirin). This needs to be recorded in the suitability assessment data set prior to the procedure commencing, as this will direct a diagnostic only test.

Participants will have received written information and a national consent form (agreed locally by the host Trust clinical governance process). The consent process will be finalised and completed together with a participant completed health questionnaire on arrival at the endoscopy unit (See appendix 4 – health questionnaire). If the participant attends without the national consent form a new one should be provided.

Participants should have self-administered their enema prior to attendance. If the self-administered enema is inadequate or has been unsuccessful and this is prior to the endoscope being inserted, the participant must be given the option of an additional (2nd) enema in the endoscopy unit. The enema used in the department will be the local Trust formulary enema of choice and given in accordance with local patient group directives or prescribed. This could be administered rectally, or if the enema is found to be unsatisfactory during the procedure, administered via the endoscope.

If the procedure has commenced the administration of a second enema is a clinical decision by the endoscopist, with the consent of the participant.

If the bowel preparation remains poor, no further enemas should be given and the endoscopist should perform as accurate and complete examination as possible within the boundaries of safety, comfort and time. There should be no more than 2 rectally administered enemas in total for the bowel scope procedure.

If the participant had not self-administered the enema, they should be offered the opportunity on arrival at the endoscopy unit.

Comfort of the participant during the bowel scope screening procedure is vital and the endoscopist should only examine the colon as far as the participant's comfort allows. In any event, examination is not expected beyond the splenic flexure (unless the participant has had a left hemi-colectomy).

The bowel scope screening procedure time is expected to be between 5 and 10 minutes.

Where the scope has been inserted and enema preparation is considered inadequate (after 2 enemas), there is no opportunity to bring the participant back for a repeat procedure on a subsequent occasion. Repeat tests are only offered where equipment or service failure occurs.

Radiological procedures as an alternative to bowel scope screening are outside the screening pathway.

The bowel scope screening procedure will be performed without sedation but with an option of Entonox for pain relief. Entonox administration must be available and used in line with local Trust policy for safe drug administration. Contraindications and potential side

effects need to be discussed with participants.

There is a requirement for the service to have endoscope processors with data capture to support the taking of photographic images.

The use of CO2 for insufflation is required as this will improve participant comfort.

Recovery space with oxygen and suction must be available in the case of any adverse event.

A clinical member of the bowel cancer screening team or endoscopy nursing team can discharge participants as soon as they are comfortable. They will receive an agreed discharge plan, contact information and instructions as to how to seek emergency help if required. If the participant has not had any tissue samples taken at the procedure, they should receive a discharge letter.

7.8 Diagnose/Histology

Patients who have had tissue samples taken which require histopathological analysis will be informed of how long it will take to receive their results and how they will be contacted to deliver the findings. Histology sampling in endoscopy will be performed in accordance with local Trust policies and protocols. The process of “right test, right patient, and right result” must be part of this policy.

Pathology reporting must be standardised within the Trust with clear pathways and protocols for the management of pathology specimens, especially if screening is performed on peripheral sites.

Pathology results must be available within 7 calendar days of receipt of the specimen within the laboratory.

7.9 Results, reporting and recording

At the end of the screening episode it will be clear that some individuals need further examination, and this may include the need for them to return for a colonoscopy (See appendix 5 - Protocol for referring patients for a Screening Colonoscopy). These patients must be seen by an SSP who can advise, manage and subsequently discharge them where appropriate.

There may be other individuals who need counselling before discharge, for example if they have had small polyps removed or who are in some discomfort, they too must be seen by the SSP.

Where samples have been taken, the data will need to be entered on to BCSS when the histology report is received. The SSP can enter all pathology data. The SP can enter all histology but cannot progress the episode, this must be undertaken by an SSP. The ASP cannot enter the histology results where the outcome is progression to screening colonoscopy.

Patients who are subject to biopsy or polyp removal, or otherwise referred for colonoscopy in the screening programme, should be added to the cancer waiting time database of the local Trust. If they are later proven to have cancer, they should receive their first treatment within 62 days of their bowel scope screening procedure.

Day 0 is the date of attendance for bowel scope. It is anticipated that services will offer same day assessments or telephone assessments for colonoscopy, to ensure the waiting times are kept to a minimum in support of national standards and to keep patient pathways as short as possible.

After colonoscopy assessment it is expected that the diagnostic test is performed within 14 days. It is important that colonoscopy is only undertaken on those patients whose histology results confirm it is necessary, using current screening referral criteria (appendix 5). Patients should be made aware of this, and anyone whose histology results do not indicate colonoscopy is necessary should be contacted, the results explained, and the colonoscopy appointment cancelled.

Patients should not undergo colonoscopy prior to histology results being returned, except where there are clear clinical indications as decided by the endoscopist.

Outcomes from screening are determined by bowel scope alone or bowel scope and additional diagnostic tests. Below is a summary of the outcomes.

Normal result at bowel scope screening:

- Discharge with bowel scope letter and endoscopy report, copy of report to GP and BCSS letter (information will be by e-comms to GP practices where possible, with a copy of endoscopy report sent by post), call for FOBt at age 60 years.

Abnormal result at bowel scope screening

- Does not meet criteria for screening follow up therefore management is in the symptomatic service. Results requiring a referral to symptomatic services should be made either by the screening centre notifying the GP who in turn refers the patient to a Consultant for on-going management or by Consultant to Consultant but with the screening centre notifying the GP that the referral has been made. The ongoing management of referrals for symptomatic patients' needs to be clarified and agreed locally.

Low risk polyp identification at bowel scope screening:

- 1 or 2 adenomas less than 10mm, discharge, enter FOBt programme at age 60 years. BCSS will close this episode and identify outcome as abnormal result.

Intermediate risk polyp identification at bowel scope screening:

- Polyp(s) <10mm in size – photograph and perform Polypectomy on all polyps of less than 10mm in size if technically safe and appropriate to do so
- If the endoscopist is confident that a polyp is not an adenoma (e.g. unequivocal hyperplastic polyp in rectum), it need not be removed or biopsied
- In the exceptional case where it is clear that the participant has many adenomatous polyps, clearance polypectomies may be deferred until the completion colonoscopy
- Offer screening colonoscopy, add index bowel scope screening to Colon findings (cumulative polyp count and size – may dictate change in surveillance to high risk).
- Intermediate risk – 3-year colonoscopy surveillance as per bowel cancer screening guidelines until out of risk category. FOBt decision based on status of surveillance. Patients may be in surveillance at the time of FOBt due date (60 years) so will need individual calculation as to when FOBt offered (this is an automated process calculated by BCSS).

High risk polyp identification at bowel scope screening:

- Polyp(s) ≥ 10 mm in size – photograph but do not remove
- Offer screening colonoscopy, add index bowel scope screening to Colon findings (cumulative polyp count and size).
- High risk - 1-year colonoscopy surveillance as per bowel cancer screening guidelines until out of risk category. FOBt decision based on status of surveillance. Patients may be in surveillance at the time of FOBt due date (60 years) so will need individual calculation as to when FOBt offered (this is an automated process calculated by BCSS).
- Polyp surveillance patients will be offered FOBt once they are discharged from surveillance if they remain within screening age range.

Cancer or suspected cancer detection:

- Photograph, take biopsies and tattoo as per local tattoo policy/guidelines
- For direct referral to MDT when a definitive diagnosis of cancer, after discussion with the patient.
- Persons with a suspicious/equivocal result should be given a colonoscopy within the programme.

(Outside scope of bowel scope screening programme):

- Refer to Colorectal Cancer MDT – symptomatic service. This is where the screening pathway ends, and the patient becomes a symptomatic patient.

Providers must ensure accurate and timely communication and handover across clinical interfaces to reduce the potential for errors and ensure a seamless pathway for patients. It is essential that there always remains clear named clinical responsibility and at handover of care, the clinical responsibility is clarified.

8 Workforce and Training

Training and education for all staff groups must be conducted in the [bowel scope guidance](#).

The Provider shall ensure all staff groups engaged in providing bowel scope screening are trained and complete continual professional development. The Provider should ensure training has been completed satisfactorily and recorded and that there is a system in place to assess on-going competency.

Clinical Director

The Clinical Director for the screening centre must be working at Consultant level directly involved in the screening service with designated sessions in their job plan to provide managerial support for the bowel cancer screening programme. If the Clinical Director is not a Colonoscopist screener, then a Clinical Lead that is a Colonoscopist screener must be appointed.

They:

- are responsible for strategic, professional and operational performance, including quality assurance (QA)
- ensure endoscopists within the programme meet all key performance indicators (KPIs) and any underachievement is acted upon
- participate in root cause analysis of adverse incidents

The clinical director is accountable for ensuring a high-quality effective bowel cancer screening programme on behalf of commissioners, delivered in line with agreed protocols. It is recommended that screening centres have a nominated deputy, to provide clinical leadership in the absence of the clinical director.

Programme Manager

There is a need for a dedicated local Programme Manager who is operationally responsible for both FOBT and bowel scope screening and is of an appropriate seniority to be accountable and responsible for the management of both programmes.

Administration staff

The Bowel Cancer Screening System (BCSS) is set up to allow for 'multiple booking' of bowel scope screening appointments, with subsequent cancellations either explicitly or implicitly due to lack of response within the time limit. There is a considerable amount of re-booking of appointments and changes to bowel scope screening lists both on internal patient administration systems and within BCSS.

The adequate number of administration staff and bookings staff will be an essential part in the efficient running of the bowel scope screening service.

Endoscopy unit workforce

A minimum of 2 nurses (1 of which must be a registered nurse) must be present during the bowel scope screening procedure. Where the endoscopist is a nurse, there is still a requirement for 2 additional people – this could be a combination of endoscopy and bowel screening nurses, but at one must be a registered nurse.

Bowel scope screening endoscopists

Bowel scope screening endoscopists must undertake the bowel scope screening [accredited assessment process](#) (See Appendix 1 – Accreditation of Bowel scope screening endoscopists) and meet the minimum standards and criteria in order to perform bowel scope screening procedures on the screening population.

Nurse endoscopists working alone for evening sessions (with no medical cover on site) will need local Trust clinical governance protocols to acknowledge autonomous practice.

Screening centres are encouraged to work with [Health Education England's](#) clinical endoscopist training programme (formerly non-medical endoscopist).

SSPs may consider undertaking training as bowel scope screeners. Training must be undertaken within a JAG accredited programme, with funding for any training supported by the individuals own trust/screening centre.

Lead Specialist Screening Practitioner

The lead specialist screening practitioner (LSSP) plays a pivotal role in leadership of the nursing team. Together with the clinical lead and programme manager they manage the day-to-day operational matters of the bowel cancer screening programme.

The LSSPs are required to lead clinical audit and benchmarking to improve clinical effectiveness in the pursuit of reduction in colorectal mortality and morbidity.

Specialist Screening Practitioners

It is particularly important that individuals attending for bowel scope screening are made to feel welcome in the bowel scope screening unit and that any questions either about the procedure or about their health are dealt with appropriately.

A minimum of one specialist screening practitioner should be present at all times during bowel scope screening sessions. The discharge of patients with abnormal findings specific to the screening programme pathways and histology sampling must be managed by specialist screening practitioners.

Screening Practitioners

A SP is a registered person that has completed the BCSS training. They are not required to do a formal educational course in bowel screening – hence they can only discuss non-adenomatous histology with patients. Any adenomatous histology must be referred to the SSP. They can work in a procedure room and input the information into the data set and support the patient during their procedure.

Assistant Screening Practitioners

The role of the ASP has been developed to support the workforce required to deliver bowel scope screening. This role does not require the individual to be a registered practitioner but does require completion of [clinical competence](#) in addition to the function of data entry within the procedure room.

ASP's are required to have completed the [national ASP induction](#) and the relevant elements of the competency package. This induction and the relevant elements of the competency package MUST be completed prior to commencing independent practice. Once deemed clinically competent the ASP must complete their BCSS training.

The ASP needs to have an understanding of relevant anatomy and physiology and pathophysiology. ASPs are also expected to be able to interact with and support participants along the screening pathway in addition to working closely alongside all members of the team.

9 Increasing uptake

Bowel scope screening is aimed at people of working age, hence screening centres should be looking to deliver weekend and evening bowel scope screening lists as well as those during normal working hours to improve accessibility.

Where possible, bowel scope screening should be delivered locally and as close to the community of the population served.

Consideration should be made for providing services in local community hospitals, independent treatment centres, mobile screening facilities, and local GP health centres, providing the facility meets the required criteria for delivering bowel scope screening.

It is recommended that:

- providers make reasonable adjustments for people who wish to partake in the programme, but might require an enema at the hospital to encourage participation - for example people who have poor bowel control, or have other medical/physical challenges that might prevent them from doing their enema at home
- commissioners and providers work with local authorities and third sector organisations to understand and develop plans to address uptake and inequalities. QA visits include an assessment of the process to develop such plans and their implementation at a local level
- text reminder services can be used according to individual Trusts local guidelines.
- providers, commissioners and local authorities are encouraged to pilot, evaluate and publish local solutions to address inequalities of access. Before piloting, these local proposals must be agreed with the PHE screening team to ensure consistency of message with nationally agreed letters
- PHE screening team will share new and emerging knowledge via the screening inequalities network and [blogs](#).

10 Information technology

The existing BCSS IT information system is bespoke for the bowel cancer screening programme and supports all elements of the bowel scope screening pathway.

Bespoke training was delivered to each screening centre to support going live to deliver bowel scope screening. As the programme matures and new staff join they are required to have training on BCSS usually delivered by NHS Digital to ensure quality and [governance](#).

The screening centre and endoscopy unit where bowel scope screening is taking place, needs to have computer terminals and printers in close proximity to enable the discharge letters and endoscopy reports to be printed for an efficient discharge process.

11 Information Governance

All providers are required to: -

- comply with the statutory data protection requirements of the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018 (DPA 2018)
- comply with the best practice guidance on collecting, analysing and disseminating confidential patient information set out in the NHS Digital (previously the Health & Social Care Information Centre) Code of Practice on Confidential Information
- comply with the best practice guidance on the management of screening records set out in the Information Governance Alliance Records Management Code of Practice for Health and Social Care 2016
- achieve, or have in place an improvement plan to achieve, at least the 'good' performance standard for the NHS Digital Data Security & Protection Toolkit
- only access screening records held in PHE-controlled IT systems that are to be used for multi-centre audit, evaluation and research purposes through the PHE Office for Data Release

12 Data and intelligence

The collection, analysis and comparison of good quality data is critical for the all NHS screening programmes in England. Monthly data is provided to support the monitoring of bowel scope screening.

PHE Screening aims to develop a consistent approach to data collection and reporting across all screening programmes and is committed to making sure that stakeholders have access to:

- reliable and timely information about the quality of the screening programme
- data at local, regional and national level
- quality measures across the screening pathway without gaps or duplications

The bowel cancer screening programme uses personal details from GP practice registration to invite people to participate in the programme. The Secretary of State for Health has given special permission to do this on the basis that cancer screening is in the public interest (Section 251 of the NHS Act 2006).

The programme takes the data from the national GP registration database just before people become eligible. Data are then collected on each screening 'episode' while people remain eligible. Data on clinicians involved in the screening process are also collected to ensure the programme maintains the highest clinical standards.

Where people move outside England and de-register from their GP practice, we retain their data in case they return in the future and need to be screened again. When people reach the age where routine screening ceases (a participant 75th birthday) their data is retained in case they decide to self-refer (opt in) to the programme.

Data from the programme is used to assure the quality and safety of screening and to evaluate and improve the way the screening process works. Data may be shared with university research departments where they have the legal and ethical permission to access it. This is overseen by PHE's Research Advisory Committee (RAC) and the Office of Data Release (ODR).

The bowel cancer screening programme fully supports the [NHS national data opt out programme](#)

13 National Standards and Quality Assurance

PHE Screening Quality Assurance Service (SQAS) systems support commissioners and the providers in the quality and clinical governance aspects of the service so that core processes are safe, and the programme achieves better outcomes. The SQAS regional teams will give ample notice to providers about QA visits – these will have a maximum interval of 5 years, but this is decided by an annual review process.

The Provider shall always cooperate and participate fully in national Quality Assurance processes, co-operate in undertaking ad-hoc audits and reviews as requested by SQAS. Commissioners may request other ad hoc audits from time to time, for example support with Health Equity Audits. Hub and Screening Centres should co-operate with such requests.

The Provider shall ensure that it submits the following to SQAS: -

- self-assessment questionnaires/tools and associated evidence - annually
- audits or data relating to nationally agreed internal quality assurance processes incidents and serious incidents as they occur in accordance with the policy.
- agreed data and reports from external quality assurance schemes, including national QA data collections on service and clinician specific activity
- minimum data set as required
- adherence to and submission of any audit requests from SQAS

13.1 Performance thresholds

The Provider will meet the acceptable and work towards the achievable programme standards. Where national recommendation for acceptable standards, KPIs and the results of internal and external quality assurance checks are made, the Provider will be expected to develop action plans. The plan will respond to any performance issues highlighted by the commissioners, having regard to any concerns raised via any feedback from service users. The plan will contain defined timescales and responsibilities and will be agreed with the commissioners.

The acceptable threshold is the lowest level of performance which screening services are expected to attain. All screening services should exceed the acceptable threshold have plans to meet the achievable threshold. Screening services not meeting the acceptable threshold are expected to put in place recovery plans to deliver rapid and sustained improvement.

The achievable threshold represents the level at which the screening service is likely to be running optimally. All screening services should aspire to attain and maintain performance at or above this level.

Screening standards give a high-level overview of the quality of screening programmes at key points on the screening pathway. They contribute to the quality assurance of screening programmes but are not, in themselves, sufficient to quality assure or performance manage screening services.

13.2 Safety concerns, bowel adverse incidents (AVIs), safety incidents and serious incidents

It is expected that: -

- providers will comply with [Managing Safety Incidents in NHS Screening Programmes](#). This is PHE's national guidance for the management of safety concerns and incidents in screening programmes. All suspected screening incidents are to be reported to the regional SQAS team and the local Screening and Immunisation team
- providers will also comply with NHS England's [Serious Incident Framework](#) until updated guidance is issued by NHS Improvement

13.3 Risk Management

The Provider shall have internal quality assurance and risk management processes in operation always and be able to demonstrate to the Commissioner that those processes are commensurate to the risks, quality assurance issues and best practice.

The Provider will be able to demonstrate that they have audited procedures, policies and protocols in place to ensure best practice is consistently applied for all elements of the screening programme.

Provider shall

- ensure that mechanisms are in place to regularly audit implementation of risk reduction measures and report incidents
- ensure that appropriate links are made with internal governance arrangements, such as risk registers;
- review and risk assess local screening pathways
- work with the Commissioner and SQAS to develop, implement, and maintain appropriate risk reduction measures

On a quarterly basis high scoring risks will be identified and agreed between the Provider and the Commissioners and plans put in place to mitigate against them. It is expected that Providers will investigate anything outside the acceptable levels.

Failsafe systems must be able to identify, as early as possible, people that may have been missed or where screening results are incomplete.

Where SQAS believe there is a significant risk of harm to the population, they will recommend to commissioners to suspend a service.

13.4 Clinical and corporate governance

Accountability and oversight

The Provider shall ensure that:

- an appropriately skilled and competent executive officer within its organisation is accountable for, and oversees, the service;
- the Provider's board of directors is part of the clinical governance procedures and must be responsible for receiving assurance on the quality of the service;

- there is appropriate internal clinical oversight of the service and have its own management and internal governance processes;
- an internal multi-disciplinary operational group is established, that meets quarterly as a minimum

Programme board

The Provider must:

- ensure co-operation with and representation on the local screening oversight arrangements/ structures; and
- ensure good governance of the screening programme; a screening programme board must meet at a minimum of every 6 months and at a schedule agreed with commissioners and must include programme director, programme manager, lead SSP, administration staff, screener representative, pathologist, radiologists, commissioners, public health and PHE SQAS representative. The programme boards must consider service user engagement and involvement.

Governance policies

The Provider must have an appropriate governance framework in place that has been approved by the Commissioner, covering the following aspects of the Services:

- Information governance/records management
- Equality and diversity
- User involvement, experience and complaints
- Failsafe procedures
- Risk register & mitigation plans.

14 Safeguarding

Safeguarding vulnerable people is at the heart of all health service delivery. NHS England and the Providers are required to ensure that services adhere to local multi agency safeguarding policies and procedures, have appropriate training in place and arrangements to work with local authorities and partner agencies through safeguarding boards and other relevant bodies.

Appendix 1

Accreditation of bowel scope screening endoscopists

- All accredited screening colonoscopists are automatically accredited for bowel scope screening
- All other endoscopists who wish to undertake bowel scope screening procedures in the BCSP will be required to be accredited for bowel scope screening before they can commence screening
- Further information is available from SaaS

Appendix 2

National Consent Form - Bowel Scope Screening

[NHS organisation name]

Consent Form 1

Adults

Participant's agreement to

NHS Bowel Scope (flexible sigmoidoscopy) screening

Participant's details (or pre-printed label)

Participant's surname/family name

Participant's first names

Date of birth

NHS number (or other identifier)

Which of the following options best describes how you think of yourself?

1. Woman (including trans woman)

2. Man (including trans man)

3. Non-binary

4. Prefer not to answer

Responsible health professional

To be retained in participant's medical case note

Participant Copy

Planned Bowel Scope Screening Test (Flexible Sigmoidoscopy or FS Screening Test)

The bowel scope screening test is an examination of the left side of large bowel using a flexible video camera.

Depending on findings, the procedure may include biopsies (small samples from bowel lining) and polypectomy (removal of growth called a polyp from the bowel wall).

Statement of health professional (to be signed by health professional in your presence at your appointment).

I have explained the procedure to the participant. In particular, I have explained:

1) The intended benefits:

Screening assessment of the left side of the large bowel to look for any signs of lower bowel cancer or for polyps, which may / could develop into cancer if left in place. Trials have shown that removing polyps significantly reduces the future risk of developing lower bowel cancer (colorectal cancer).

2) Serious or frequently occurring risks:

Serious bleeding after biopsy or polypectomy – uncommon (1 in 3000); Missing serious pathology – uncommon (1 in 1000); Perforation of the bowel wall – rare (1 in 40,000).

3) Any extra procedures which may become necessary during the procedure:

Subject to findings, a follow-up full colonoscopy may be recommended in order to allow a full view of the whole large bowel. A colonoscopy is sometimes needed to safely remove certain polyps (for which a separate appointment will be arranged). Samples for histology - the procedure may involve biopsy of tissue and/or polypectomy (removal of polyps) for diagnostic purposes. Following diagnosis this tissue will form part of the clinical record.

Blood transfusion - uncommon (1 in 3,000) in the event of serious bleeding
Operation (1 in 10,000 or rare) may be required if there is life threatening bleeding or if a hole is made through the bowel wall (perforation).

4) Retention of tissue samples for training and research:

Any tissue samples taken may be retained and used for teaching purposes and for research aimed at improving diagnosis and treatment of bowel cancer in line with the relevant local Trust policy. To refuse permission for this, the choice options in the "Statement of Participant" (Page 4) can be completed.

I have also discussed what the procedure is likely to involve and the fact that the national screening programme does not offer an alternative to this particular test for bowel cancer screening for individuals in this age range. I have explained that a different test (FOBT) is available only from age 60 to age 74. I have also discussed any particular concerns the participant has raised.

The national standard "Bowel scope screening" leaflet has been provided.
This procedure will not involve any general or local anaesthesia or any sedation other than the possible use of Entonox (gas and air) with your prior agreement

Signed : (Health professional) Date

Name (PRINT) Job title

5) Contact details (if participant wishes to discuss options later)

Statement of interpreter (where appropriate)

I have interpreted the information above to the participant to the best of my ability and in a way in which I believe s/he can understand.

Signed Date

Name (PRINT)

Copy for medical case notes

Planned Bowel Scope Screening Test (Flexible Sigmoidoscopy or FS Screening Test)

The bowel scope screening test is an examination of the left side of large bowel using a flexible video camera.

Depending on findings, the procedure may include biopsies (small samples from bowel lining) and polypectomy (removal of growth called a polyp from the bowel wall).

Statement of health professional (to be signed by health professional in your presence at your appointment). I have explained the procedure to the participant. In particular, I have explained:

1) The intended benefits:

Screening assessment of the left side of the large bowel to look for any signs of lower bowel cancer or for polyps, which may / could develop into cancer if left in place. Trials have shown that removing polyps significantly reduces the future risk of developing lower bowel cancer (colorectal cancer).

2) Serious or frequently occurring risks:

Serious bleeding after biopsy or polypectomy – uncommon (1 in 3000); Missing serious pathology – uncommon (1 in 1000); Perforation of the bowel wall – rare (1 in 40,000).

3) Any extra procedures which may become necessary during the procedure:

Subject to findings, a follow-up full colonoscopy may be recommended in order to allow a full view of the whole large bowel. A colonoscopy is sometimes needed to safely remove certain polyps (for which a separate appointment will be arranged).

Samples for histology - the procedure may involve biopsy of tissue and/or polypectomy (removal of polyps) for diagnostic purposes. Following diagnosis this tissue will form part of the clinical record.

Blood transfusion - uncommon (1 in 3,000) in the event of serious bleeding

Operation (1 in 10,000 or rare) may be required if there is life threatening bleeding or if a hole is made through the bowel wall (perforation).

4) Retention of tissue samples for training and research:

Any tissue samples taken may be retained and used for teaching purposes and for research aimed at improving diagnosis and treatment of bowel cancer in line with the relevant local Trust policy. To refuse permission for this, the choice options in the "Statement of Participant" (Page 4) can be completed.

I have also discussed what the procedure is likely to involve and the fact that the national screening programme does not offer an alternative to this particular test for bowel cancer screening for individuals in this age range. I have explained that a different test (FOBT) is available only from age 60 to age 74. I have also discussed any particular concerns the participant has raised.

The national standard "**Bowel scope screening**" leaflet has been provided.

This procedure will not involve any general or local anaesthesia or any sedation other than the possible use of Entonox (gas and air) with your prior agreement

Signed : (Health professional) Date

Name (PRINT) Job title

5) Contact details (if participant wishes to discuss options later)

Statement of interpreter (where appropriate)

I have interpreted the information above to the participant to the best of my ability and in a way in which I believe s/he can understand.

Signed Date

Name (PRINT)

Copy accepted by participant: yes/no (please circle)

Statement of participant:

Please read this form carefully and in particular page 2 above which describes the benefits and risks of the Bowel Scope screening test. If you have any further questions, you will have the opportunity to discuss these with a screening health professional when you arrive at your appointment. We are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures which I do not wish to be carried out without further discussion.

.....
.....

I understand that unless I refuse permission by ticking the following options, any tissue samples may be retained and used for teaching purposes and for research aimed at improving diagnosis and treatment of bowel cancer in line with relevant local Trust policy.

My tissue samples are not to be used for teaching

My tissue samples are not to be used for research

To be signed by the participant either in advance of the appointment or at the appointment itself in advance of the bowel scope screening test.

Participant's signature Date

Name (PRINT)

A witness should sign below if the participant is unable to sign but has indicated his or her consent.

Witness Signature Date

Name (PRINT)

Confirmation of consent (to be completed by a health professional when the participant is admitted for the procedure, if the participant has signed the form in advance)

On behalf of the team treating the participant, I have confirmed with the participant that s/he has no further questions and wishes the procedure to go ahead.

Signed: Date

Name (PRINT)

Job title

Important Note: Tick if applicable

Seen advance directive/living will (e.g. Jehovah's Witness form)

Participant has withdrawn consent (ask participant to sign here)

Signed

Name (PRINT).....

Date.....

Appendix 3

National Enema

The nationally procured enema must be distributed to all participants who agree to take part in the bowel scope screening programme.

Instructions for [using/administering the Enema](#) are available in many languages.

Appendix 4

Patient Identity Label

HEALTH QUESTIONNAIRE

Do you have, or have you ever had	Yes	No	Comment
Heart Problems or heart attack in the last 3 months.	<input type="checkbox"/>	<input type="checkbox"/>	
Breathing Problems?	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal Operations?	<input type="checkbox"/>	<input type="checkbox"/>	
GI Investigation? (examinations or scans of your stomach or bowels)	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been advised by a Public Health official that you are at risk of developing CJD or vCJD?	<input type="checkbox"/>	<input type="checkbox"/>	
Blood disorders? (Anaemia, clotting disorders etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Have you administered your enema	<input type="checkbox"/>	<input type="checkbox"/>	
Did the enema work i.e. produce a bowel motion?	<input type="checkbox"/>	<input type="checkbox"/>	Only if answer NO should a second enema be administered.
Do you take any of the following medication prescribed by a doctor?	Yes	No	Comment
Warfarin	<input type="checkbox"/>	<input type="checkbox"/>	
Clopidogrel (Plavix)	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin	<input type="checkbox"/>	<input type="checkbox"/>	
Any other prescribed medication (Please list)	<input type="checkbox"/>	<input type="checkbox"/>	

Are you allergic to: **Latex?** **Any food type?** **Any medication?**

If Yes, please provide details)

.....

Do you have any disabilities or additional needs you would like us to know about?

Please tick all that apply:

Learning

Sight Hearing

Manual Dexterity

Mobility Speech Continence

Other (please give detail)

Appendix 5

Protocol for referring a patient for a screening colonoscopy

The following patients should be referred for colonoscopy in the Bowel Cancer Screening Programme:

- Any patient with a polyp >10mm
- Any patient with, on a histological report
 - 3 or more adenomas
 - An adenoma with villous or tubulovillous component
 - An adenoma with high-grade neoplasia (dysplasia)
- Patients with 20 or more polyps which are >3mm, hyperplastic in appearance and above the distal rectum.

The following patients will be referred for colonoscopy in the Bowel Cancer Screening Programme:

Any patient with suspected adenomas, which fit criteria for removal but where this may not be appropriate at initial flexible sigmoidoscopy screening procedure

e.g.

- On warfarin anti-coagulant or antiplatelet therapy (lesions e.g. cancers may be biopsied, but polyps should not)
- On DOACs (biopsies should not be taken)
- Patient intolerance of procedure / discomfort
- Multiple suspected adenomas >6
- At risk of vCJD
- A patient with a polyp which is technically difficult to remove e.g. due to poor access, in an unstable position, or recurrence in a previous polypectomy scar

Notes

Adenomas will be summated from all endoscopy examinations to determine appropriate surveillance interval

Any polyp not retrieved is assumed to be an adenoma

Hyperplastic-looking polyps < 5mm in rectosigmoid area need not be removed where the endoscopist is confident that they are safe to leave in situ.