

## **6. NHS Boards**

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

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

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

NHS Boards have responsibility:-

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

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

accessed on the ISD website at [New Cancer Waiting Times Targets](#)

## **6.1 Support and Publicity to Encourage Uptake**

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

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

NHS Health Scotland will support annual roll-out of the campaign with NHS Boards. A portfolio of communications material is available and NHS Health will continue to monitor and evaluate the content of the material. NHS Health Scotland will also brief local coordinators on the aims and objectives of the campaign.

NHS Boards are responsible for ensuring:

- readiness for accepting roll out of the campaign and taking ownership of local publicity,
- increasing knowledge with clinicians both in primary and secondary care,
- identifying local priority groups and targeting them accordingly,
- identifying local opportunities to increase uptake and promotion of campaign material and information, and
- providing information about follow-up tests and treatment.

(See Chapter 7 – Communication Strategy)

NHS Boards have a responsibility to develop protocols for:

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

(See Chapter 8 for more information)

## **6.2 Referral of Screening Test Positive Individuals**

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

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

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

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

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

## **6.3 Pre-assessment for colonoscopy**

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

Once notification of an individual with a positive result is received by the NHS Board, demographic details must be recorded to

ensure each individual is followed up for further investigation. It is suggested that a simple data base showing outcome for each individual will be required to failsafe the process.

It is also suggested that in all cases a single assessment pro-forma is used to pre-assess screening participants for colonoscopy (see Appendix 4).

If a screening participant defaults at this stage (either fails to respond or to attend) a reminder should be sent. This is in recognition that screening participants have had no contact with a health care professional up until the point of pre-assessment.

If there is no response to the follow-up the NHS Board takes action as per a symptomatic patient and notifies the GP practice. This notification is for information only and will be the end of the screening pathway.

If there is a change of mind, subsequent referral should be made by the usual symptomatic service approach.

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

The pre-assessment is an essential step to assess health fitness for the procedure. Some individuals may be assessed as high risk for colonoscopy and certain precautions need to be taken to minimise risk during the procedure. These include individuals who:

- are receiving warfarin medication,
- have insulin dependant diabetes mellitus,
- have prosthetic heart valves,
- are undergoing peritoneal dialysis,
- are receiving immunosuppressing medication, and
- have a previous history of endocarditis.

Other individuals may be deemed high risk for a screening colonoscopy due to significant co-morbid disease. The health care professional, with responsibility for pre-assessment, will co-ordinate a multidisciplinary discussion and the decision to safely proceed to referral, to keep the screening participant informed of progress, and to assist in making an informed choice about proceeding to colonoscopy (See Appendix 5).

Individuals who would be excluded from having a screening colonoscopy are:

- individuals who have had surgery in the past to remove their entire colon and rectum,
- individuals who have had a complete colonoscopy in the previous 12 months,
- individuals who have had a myocardial infarct in the past 3 months (colonoscopy can be delayed to minimise risk), and
- any individual who is experiencing any acute or severe inflammatory process at the time such as ulcerative colitis, Crohn's disease or acute diverticulitis.

In cases where the decision has been made not to progress with a colonoscopy the health care professional should inform the General Practitioner outlining the reason. In the case of individuals who decide not to participate following pre-colonoscopy assessment, the General Practitioner should be informed by letter. Again the GP can refer by the usual symptomatic service approach if there is a change of mind.

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

A Quality Assurance Pre-colonoscopy Assessment sub-group of the Bowel Screening Programme Board is being established with the main remit of ensuring consistency of approach across Scotland. Remit and membership is still to be finalised.

## **6.4 Colonoscopy**

### **6.4.1 See NHS Quality Improvement Scotland (NHS QIS) Bowel Screening Clinical Standards (published February 2007).**

There is evidence that waiting for colonoscopy creates anxiety (see NHS QIS Standard 6, Colonoscopy and Histopathology). In at least 95% of cases the interval between the notification of the positive screening text result to the NHS Board and the date offered for colonoscopy should be within 31 days. The health care professional with responsibility for pre-assessment should endeavour to ensure that any clinical induced delays or patient choice delays are kept to a minimum.

### **6.4.2 Incomplete colonoscopy**

Failure to complete colonoscopy may result in significant neoplasia being missed. A date for a barium enema or a computed tomography (CT) colonography should be offered within 31 days of an incomplete colonoscopy (see NHS QIS Standard 6 c – A completion investigation of the entire large bowel is carried out after incomplete colonoscopy).

### **6.4.3 Colonoscopy findings**

In order to minimise a participant's anxieties, the findings of colonoscopy should be discussed following the procedure. To ensure a seamless pathway of care between secondary and primary care, delays in written communication should be kept to a minimum.

The findings of the colonoscopy should be discussed with the participant as soon as the participant is awake enough to be receptive to this. Ideally this should be followed up with a discussion with the person responsible for collecting the individual if the participant permits. Individuals should be told verbally what the next stage is e.g. no follow-up, barium enema or awaiting biopsy results.

## **6.5 Collection of minimum dataset for all bowel screening referrals**

A minimum dataset has been developed to monitor and evaluate the Bowel Screening Programme. NHS Boards are responsible for collection of this minimum dataset for all individuals with a positive screening test result. This information should then be submitted to colleagues at Information Services (ISD) Scotland Services within six months of a positive test result.

## **6.6 Submission of data to Information Services NHS National Services Scotland (ISD)**

Non-clinical information is provided by BoSS (the Bowel Screening IT system) and clinical information is provided by the individual NHS Boards. The 14 NHS Boards may use different software packages to generate the data file and, to accommodate this, a specification of the data items to be collected and the format required has been developed.

### **6.6.1 BoSS**

Non-clinical data should be in csv format (comma separated value), in the correct order with the column headings as per the minimum dataset BoSS specification.

### **6.6.2 NHS Boards**

The clinical data should be in csv format (comma separated value), in the correct order with column headings as per the minimum dataset NHS Board specification (see Chapter 5.4).

### **6.6.3 Submission of information to ISD**

Bowel Screening Information from BoSS and the Health Boards – Submitting the Minimum Dataset – Instructions. The most up-to-date version (v.5) has been circulated to NHS Boards and is also available on request.

## **6.7 Escalation Procedures**

Any screening programme has the potential for significant adverse incidents. It is important to audit incidents with the aim of minimising risk. In this way improvements in practice can be identified and disseminated to a wider group. There is also potential for an incident to occur at any stage in the screening process and for complaints/issues about the service to become high profile.

NHS Quality Improvement Scotland (NHS QIS) has developed Bowel Screening standards covering six key areas:-

- general
- call-recall
- the screening process
- the laboratory process
- pre-colonoscopy assessment
- colonoscopy and histopathology

As the bowel screening programme is the responsibility of both the local NHS Boards and the Scottish Bowel Screening Centre (SBoSC) based in Dundee separate escalation procedures have been developed for the SBoSC and for NHS Boards.

NHS Board responsibilities are set out below:-

- provide support and publicity to encourage uptake.
- develop protocols for travellers and homeless people and those in long stay institutions,
- establish receiving arrangements for SCI Gateway referrals from BoSS
- pre-assessment for colonoscopy
- colonoscopy
- collection of a minimum dataset for all bowel screening referrals
- download data to Information Services NHS National Services Scotland (ISD) and
- production of annual reports on the performance of bowel screening in their area.

The following covers escalation procedures within these areas.

A Scottish Bowel screening Programme Governance Strategy has been developed setting out the key roles, responsibilities and relationships for the programme and providing a strategic framework for the development of clinical governance over the next five years. It is essential that management of risks relating to the Bowel Screening Programme are set within the context of this Governance Strategy and individual NHS Boards' systems of governance and risk management.

The methodology for ascribing levels of risk should be consistent with local proactive risk assessment, risk management and incident reporting processes already in place. Identifying the likelihood of most events occurring can be subjective and based upon the knowledge and expertise of those involved. Evidence and statistics may however be available regarding the recurrence of certain events and this information can help anticipate and plan.

**Annex A** sets out the escalation framework for NHS Boards.

**Annex B** includes an escalation flowchart for NHS Boards

**Annex C** – Categorisation of Risks - example

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**ANNEX A**

**SCOTTISH BOWEL SCREENING PROGRAMME**  
**Escalation Procedures for NHS Boards**

1. Any healthcare professional involved in the Scottish Bowel Screening programme who becomes aware of a suspected problem should follow their agreed local NHS Board clinical governance procedures and the Bowel Screening Programme escalation procedures.

**GREEN**

2. If local investigation concludes that the problem will only have minimal impact and the risk assessment is **Green**, local governance procedures should be followed and the local Service Manager advised to ensure that effective countermeasures are put in place to resolve the issue satisfactorily.

**AMBER**

3. If a fairly significant problem is identified (and the risk assessment is **Amber**) but there is no cessation in service provision then the local Service Manager, the NHS Board Lead Bowel Screening Clinician and the NHS Board Screening Co-ordinator should be advised and planned action initiated to resolve the problem. The Programme Manager, Scottish Bowel Screening National Services Division (NSD) should also be advised of the problem and the action taken and outcome.
  - 3.1 If the action successfully resolves the problem a report should be provided to NSD. The NHS Board should continue to monitor for recurrence.
  - 3.2 If the action does not resolve the problem then it should be treated as having a significant impact and the risk assessment should be escalated to Red.

## **RED**

4. A major/catastrophic problem is defined for example as the NHS Board being unable to meet service provision or the occurrence of a significant clinical incident. It also includes the cessation of services that will impact on screening participants e.g. cancellation of colonoscopy sessions or loss of key staff for an extended period of time is likely or necessary and can not be resolved locally and there is the potential for adverse publicity. In these circumstances the NHS Board Chief Executive, NHS Board Screening Co-ordinator, the local NHS Board Lead Bowel Screening Clinician and NSD should be alerted immediately on the extent of the problem by the relevant local Service Manager. A detailed report should be forwarded to NSD on the extent of the problem and including potential solutions.
- 4.1 Depending on the nature of the incident NSD in discussion with local Screening Co-ordinator, Managers and Lead Clinician will agree actions to be taken. NSD will also inform the Scottish Government Health Directorate (SGHD) of the problem and the agreed action plan. The Bowel Screening Governance Committee will also receive a detailed report in due course.
- 4.2 The agreed action plan is implemented by the NHS Board and NSD will monitor and report to the SGHD and the Bowel Screening Governance Group.
- 4.3 If the action plan resolves the problem a report should be provided to NSD. The NHS Board and NSD should continue to monitor for recurrence.
- 4.4 If the Action Plan does not resolve problem then NSD and SGHD will consider further action and whether a full independent external investigation/peer review is instigated.

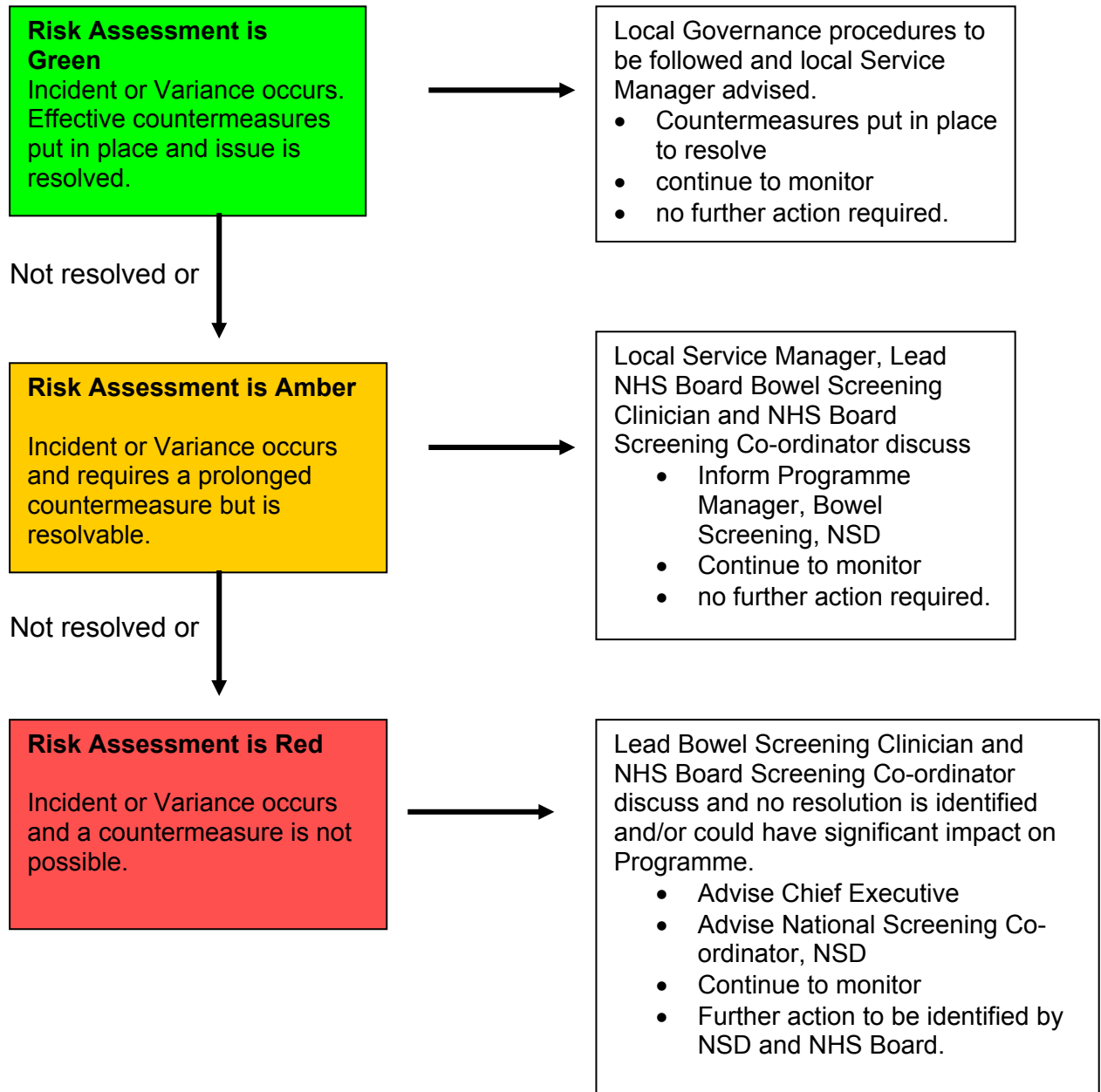
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**ANNEX B**

**SCOTTISH BOWEL SCREENING PROGRAMME**  
**Escalation Procedures for NHS Boards**

Resolved



**ANNEX C**

**SCOTTISH BOWEL SCREENING PROGRAMME  
Escalation Procedures for the NHS Boards**

**Categorisation of Risks - Example**

<b>Description</b>	<b>Strategic</b>	<b>People</b>	<b>Operational</b>	<b>Clinical</b>	<b>External</b>
<b>GREEN</b>	Minimal impact on the Programme Scope	Minimal disruption to staff/very minor delay in recruiting staff. Minor H & S incident/minor staff complaint/short-term vacancy.	Minimal impact – no service disruption/no adverse publicity.	No obvious clinical harm or injury to participant.	Minimal impact on services or operations.
<b>AMBER</b>	Minor/ Moderate impact/change to Programme scope.	H & S incident with some harm/staff unrest/key post vacant/ unable to recruit skilled staff to key roles for extended period.	Minor impact on service provision due to capacity issues/some public embarrassment/some objectives partially achievable/local adverse publicity.	Injury/harm/ medical intervention required e.g screening referral dealt with inappropriately	Impact requiring change to services to comply with new legislation or directions.
<b>RED</b>	Major/ Complete change impacting on the original fundamental programme scope	Severe H & S incident/industrial action/sustained loss of key groups of staff/ causing termination of operations.	Significant impact on service provision/unable to function or carry out programme obligations/ highly damaging national or international publicity.	Major clinical complication e.g. as a result of colonoscopy resulting in significant harm/injury to a screening participant.	Significant and costly change to comply with legislation and directions.

## **6.8 Annual Reports on the performance of bowel screening in their area**

ISD Scotland will provide annual key performance indicators (KPIs) nationally and to all individual NHS Boards (see Appendix 3 and Chapter 5 – NHS National Services).

The first Programme KPI report, which was released in August, is available at:

<http://www.isdscotland.org/isd/810.html>