Bowel Screening Wales

Health Professional Information

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Acknowledgements

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Bowel Cancer

Background Information

**Incidence and Mortality**
Colorectal cancer is the third most common cancer in Wales with over 2000 new cases diagnosed each year, and approximately 1000 deaths per year (CSCG 2008). Bowel cancer is more common on the left side of the colon than on the right, with approximately 63% of cases occurring in the colon, 29% in the rectum and 8% in the rectosigmoid junction. The lifetime risk of being diagnosed with bowel cancer is around 1 in 20 for women and 1 in 18 for men.

Table 1 illustrates the incidence of colon cancer and rectal cancer in men and women (WCISU 2008).

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Males</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon</td>
<td>1037</td>
<td>1113</td>
<td>1111</td>
<td>1135</td>
<td>1210</td>
</tr>
<tr>
<td>Rectal</td>
<td>436</td>
<td>437</td>
<td>444</td>
<td>465</td>
<td>482</td>
</tr>
<tr>
<td><strong>Females</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal</td>
<td>864</td>
<td>853</td>
<td>894</td>
<td>847</td>
<td>934</td>
</tr>
<tr>
<td>Total</td>
<td>1971</td>
<td>1966</td>
<td>2005</td>
<td>1982</td>
<td>2144</td>
</tr>
</tbody>
</table>

**Survival rates**
Table 2 illustrates the five year survival rates according to the Dukes’ stage classification (Cancer Research UK 2006).

<table>
<thead>
<tr>
<th>Dukes’ stage</th>
<th>Five year overall survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>85-95%</td>
</tr>
<tr>
<td>B</td>
<td>60-80%</td>
</tr>
<tr>
<td>C</td>
<td>30-60%</td>
</tr>
<tr>
<td>D</td>
<td>&lt;10%</td>
</tr>
</tbody>
</table>
Risk Factors
Although the cause of bowel cancer is not fully understood, possible risk factors have been identified:

- **Age/sex** – The development of bowel cancer is strongly associated with age. More than 80% of cases occur in those aged 60 and over. Men and women have a similar risk of developing bowel cancer up to age 40, but after this rates are higher for men.

- **Diet and lifestyle** – There is some evidence to suggest that individuals who rarely exercise, individuals who are overweight and individuals who have a diet high in red meat, low in fruit and vegetables and low in fibre are at an increased risk of developing bowel cancer.

- **Family history** – Less than 10% of all colorectal cancers are genetically linked. Individuals with either one first-degree relative diagnosed with bowel cancer before the age of 45 or two first-degree relatives diagnosed at any age have an increased risk of developing bowel cancer. For these individuals, the lifetime risk increases to 16-25% in men and 10-15% in women. Having one first-degree relative diagnosed with bowel cancer between 45 – 65 years of age increases the lifetime risk but not enough to justify regular screening colonoscopy. Having one first-degree relative diagnosed with bowel cancer at or over 65 years of age leads to only a slightly increased lifetime risk of developing bowel cancer.

Natural Disease Progression
Over 90% of bowel cancer cases are adenocarcinomas, and of these, most arise adenomatous polyps. Adenomatous polyps increase in prevalence with age, and are present in approximately one in four people by the age of 50. Studies suggest that 1-10% of polyps transform into invasive cancers. The development of a polyp into a cancer can take more than 10 years, with larger size, villous histology and severe dysplasia being important predictors of progression to invasive cancer. Adenomas that are flat or depressed account for 10% of cases. These are characteristically harder to detect and may carry a higher risk of malignancy.

Symptoms and signs
Rectal bleeding, a change in bowel habit and anaemia are the most common presenting symptoms of bowel cancer. Nausea, weight loss, abdominal pain and anorexia may be experienced in more advanced disease. While individual symptoms may be poor predictors of bowel cancer, the presence of a combination of signs and symptoms is more sensitive and specific.
The National Institute for Health and Clinical Excellence (NICE) recommends urgent referral for patients:

- Aged >40 years who report rectal bleeding with a change of bowel habit towards looser stools and/or increased stool frequency persisting for six weeks or more.
- Aged >60 years who report rectal bleeding persisting for six weeks or more without a change in bowel habit and without anal symptoms.
- Aged >60 years who report a change in bowel habit to looser stools and/or more frequent stools persisting for six weeks or more without rectal bleeding.
- Of any age with a right lower abdominal mass consistent with involvement of the large bowel.
- Of any age with a palpable rectal mass (intraluminal and not pelvic; a pelvic mass outside the bowel would warrant an urgent referral to a urologist or gynaecologist).
- Who are men of any age with unexplained iron deficiency anaemia and a haemoglobin level of <11 g/100 ml.
- Who are non-menstruating women with unexplained iron deficiency anaemia and a haemoglobin level of < 10 g/100 ml.

Please note:
Bowel screening is a service for asymptomatic individuals. It is not the appropriate investigation for individuals with symptoms. A negative screening test result in a symptomatic person can give false reassurance and lead to avoidable delay in diagnosis.

Genetic Conditions
Familial adenomatous polyposis (FAP) accounts for around 1% of cases of bowel cancer. Patients develop hundreds or thousands of polyps in the colon and rectum in their twenties and thirties, and have almost a 100% chance of developing bowel cancer before they are fifty years old. Individuals with FAP are usually offered prophylactic colectomy in their teens or twenties.

Hereditary non-polyposis colorectal (bowel) cancer (HNPCC) accounts for around 2-5% of cases of bowel cancer. Polyps develop at a younger age and at a greater frequency than in individuals who do not have the disease, but not in such large numbers as in FAP. HNPCC is linked to bowel cancer in younger age groups and is the cause of around 40% of cases in individuals under 30 years of age. There may be other non-colorectal associated sites affected with the syndrome e.g. endometrium, ovary, stomach, pancreato-biliary system and urinary tract. The original definition of HNPCC has been modified to encompass the excess risk of endometrial cancer.
As a result, HNPCC is now defined as:

- three or more family members affected by colorectal cancer (CRC) or
- >2 with CRC and one with endometrial cancer in >2 generations (one affected relative must be age <50 at diagnosis, one of the relatives must be a first degree relative of the other two).

As the causative genes have been identified (ICG database), fulfillment of these criteria is not an absolute requirement for classification as HNPCC, as colorectal cancer sufferers have been identified as gene carriers despite having fewer affected relatives than outlined above.

Enhanced surveillance by colonoscopy is advisable for people with a significant family history whereas routine FOBT screening is more appropriate for the general population.

Patients with a significant family history of 2 first degree relatives with bowel cancer or 1 first degree relative under the age of 45 years will be advised to attend their GP practice for referral to the Medical Genetics Service.

Screening

Screening is “a public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of disease or its complications” (NSC2000). The NSC has criteria which must be satisfied prior to implementation of a national screening programme.

These include:

- The condition must pose an important public health problem
- The natural history of the condition must be understood
- Early treatment must be beneficial and supported by empirical evidence
- A suitable test or examination must be available
- The test must be acceptable to the population
- The test must be reproducible
- The benefit must outweigh the harm
- Screening must be cost effective
Bowel Cancer Screening

Research Evidence

Four randomized controlled trials (RCTs) of mass population screening using the faecal occult blood test (FOBt) have been carried out: one in the UK, one in Denmark, one in the USA and one in Sweden. These trials demonstrated a reduction in bowel cancer specific mortality in the screened groups, using biennial screening, annual screening or a combination of the two and with follow up periods ranging from 11 to 18 years. A meta-analysis of these four trials reported a 16% reduction in bowel cancer specific mortality with screening.

UK Pilot Programme

Following these demonstrations of mortality reduction, the Department of Health commissioned a pilot screening programme to assess the feasibility of using biennial FOBt screening as a population based screening tool for bowel cancer in the UK. Three pilot screening rounds for men and women aged 50-69 years were successfully implemented in Coventry and Warwickshire in England and in Tayside, Grampian and Fife in Scotland. The first round of screening demonstrated that screening for bowel cancer using the FOBt is feasible within the context of the NHS.

Table 3 shows the proportion of cancers detected by screening for each Dukes’ stage during the first phase of the screening pilot in England.

Table 3: Stage at Detection

<table>
<thead>
<tr>
<th>Stage</th>
<th>Cancers Detected</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening Service</td>
<td>Symptomatic Service</td>
</tr>
<tr>
<td>Unstaged polyp cancers</td>
<td>17%</td>
<td>2%</td>
</tr>
<tr>
<td>Dukes’ stage A</td>
<td>25%</td>
<td>13%</td>
</tr>
<tr>
<td>Dukes’ stage B</td>
<td>26%</td>
<td>28%</td>
</tr>
<tr>
<td>Dukes’ stage C</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Dukes’ stage D</td>
<td>2%</td>
<td>25%</td>
</tr>
<tr>
<td>Other unstaged cancers</td>
<td>5%</td>
<td>4%</td>
</tr>
</tbody>
</table>

The English and Scottish bowel screening programmes have been developed based on the findings of the pilot. Both programmes use biennial FOBt home kits followed by colonoscopy if the test is positive and aim to achieve national coverage by 2009.
The bowel screening programme in Wales will be established and managed by Screening Services, which is part of Velindre NHS Trust. The Welsh Bowel Screening Centre is situated at Unit 6, Green Meadow, Llantrisant, CF72 8XT and houses the central administration department and national screening laboratory. All acute Trusts in Wales will participate in the programme by providing Specialist Screening Practitioner (SSP) assessment and follow-up, together with endoscopic and radiological investigations. Initially, people aged between 60 – 69 years who are resident in Wales will be invited to take part. The programme will be phased in by age range (60-69, then adding those aged 70-74, and finally those aged 50-59 years) until screening is offered to all eligible people aged 50 – 74 throughout Wales. Self Referral into the programme by requesting a testing kit will not be possible until this stage is reached.

Completed test kits will be returned to the laboratory and will be processed the same day. Administrative staff will co-ordinate the call/recall system for eligible people; ensuring participants with a positive result are referred for further assessment to Specialist Screening Practitioners (SSP) at each of the participating trusts.

Administrative staff, in conjunction with laboratory screeners, will man a national telephone helpline between the hours of 8.00am and 6.00pm.

The bowel screening centre staff will manage the call/recall process, testing of FOBT kits and dispatch of test results. The centre will be responsible for arranging SSP appointments for individuals with positive FOBT results. The SSP will be responsible for guiding people with a positive result through the colonoscopy process until the time they are either returned to routine recall or diagnosed and referred to the MDT. BSW are responsible for participants until the point of cancer diagnosis. It is also responsible for those people with large and/or multiple adenomas, who will be invited to participate in the surveillance programme. People on the surveillance programme will not be recalled for FOBT screening.
The Screening Process
Invitations and test kits will be sent to eligible people every 2 years. People with a positive FOBt result will receive a letter asking them to contact the central administration department. An appointment with the SSP will be offered. This will be the participant’s first contact with a health professional during the screening process. The initial assessment will be offered as a telephone assessment. If a face to face consultation is requested by the participant or deemed necessary by the SSP following the telephone assessment an appointment at the local assessment centre will be made. The assessment interview includes an explanation of the implications of the result and a discussion about the colonoscopy procedure including risks. An assessment of fitness for colonoscopy will be conducted, and an appointment for a colonoscopy offered if appropriate and acceptable to the participant. Radiological investigations may be offered to individuals who are not fit for colonoscopy. Arrangements for the supply and self administration of bowel preparation will also be made at the initial assessment.

Colonoscopy will be undertaken by Screening Colonoscopists in local assessment centres in Wales. If nothing abnormal is detected on colonoscopy people will be invited for screening again in 2 years time. People found to have cancer will be referred to the multi disciplinary team. If polyps are found and removed participants will be offered surveillance depending on the classification of polyp according to BSG guidelines.

The Screening Test
The faecal occult blood test (FOBt)
Individuals will be sent a Guaiac FOBt kit (gFOBt), which is to be completed at home. The kit comes with an information leaflet, cardboard sticks with which to collect the samples from bowel motions and a “Freepost” envelope in which to return the kit for analysis at the screening laboratory.

There are three flaps on the test kit, each with two ‘windows’ underneath. Two tiny samples are taken from a bowel motion and spread onto each of the two windows under the first flap using the cardboard sticks provided. The flap is then sealed, and the process is repeated for the second and third bowel motions (using the windows under the second and third flaps respectively). Each sample is to be collected on three consecutive but separate days. Once all six windows have been smeared, the kit should be returned to the laboratory for analysis. The kit must be returned within 14 days of the first sample being taken to ensure that a reliable result can be obtained.

Faecal occult blood test uptake (from English and Scottish data)
Over 1 million people have now been invited to take part in the English programme. Most recent results (March 2008) from the screening programme in England show the uptake of FOBt screening is approximately 52%. There is however considerable regional variation in uptake – currently between 27% and 61%. Younger women demonstrate an increased uptake when compared to men. As women get older their uptake decreases while men are more likely to comply as they get older.

Positive rates of FOBt in England demonstrate a North-South divide in England which is not concordant with bowel cancer rates.
Test results
Participants will receive a letter giving them the results of their test within two weeks of the gFOBt kit being received for analysis at the laboratory. The possible results of gFOB tests are shown in table 4.

Table 4: FOBt Results

<table>
<thead>
<tr>
<th>Result</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>No detection of blood</td>
</tr>
<tr>
<td>Unclear</td>
<td>1-4 windows show blood</td>
</tr>
<tr>
<td>Positive</td>
<td>5-6 windows show blood</td>
</tr>
</tbody>
</table>

Individuals who receive an unclear result following their first FOBt are sent a different test kit called the immunochemical test (FIT) kit. Immunochemical tests (iFOBT) are specific to human haemoglobin and have lower false positive rates. They are newer tests and are more expensive than the gFOBt.

A two-tier reflex follow-up of equivocal FOBt results with an immunochemical test before colonoscopy has been demonstrated to be an efficient and effective approach. (Figure 1 illustrates possible test results).

Figure 1: Possible FOBt results

Wales will use an immuno-chemical test kit for unclear results on a guaiac FOBt – following the Scottish model.

This 2 tier testing model will result in fewer colonoscopies being offered.
The sensitivity of FOBt, i.e. the proportion of individuals who have bowel cancer that test positive, has been reported to be 55.0-92.2% in RCTs. A direct comparison of gFOBT and iFOBT in over 10,000 participants in a screening programme showed that at a positivity threshold of 75 ng Hb/ml the iFOBT was more sensitive. For the detection of advanced neoplasia (colorectal cancer, adenoma >10 mm or high grade dysplasia) the ratio of sensitivities (iFOBT/gFOBT) was 1.90 (95% CI 1.41 – 2.56) and the ratio of false positive rates 0.67 (0.53 – 0.86) (Guittet L et al 2007). At this threshold the positivity rate (2.4%) was the same as the gFOBT. Fraser et al concluded that the two-tier approach to be used in Wales reduced the number of false positives and thus the number of colonoscopies required by about 30% compared with repeat gFOBT (Fraser 2007).

Diet and the faecal occult blood test
It has been suggested that certain foods, for example red meat and some vegetables, may react with the FOBt and increase the rate of false positive results if the tests are rehydrated (by adding distilled water to the test at analysis). Data from RCTs using unrehydrated test kits have demonstrated no significant effect of dietary restriction on positivity rates, but that more severe dietary restrictions may decrease participation. Dietary restrictions are not required for people undergoing the FOBt in the welsh bowel screening programme, which uses unrehydrated tests.

Diagnostic Testing
The colonoscopy procedure
Individuals undergoing colonoscopy will routinely receive their bowel preparation by post following discussion with the SSP. They will also receive an information booklet about colonoscopy with a consent form. Following assessment the SSP will offer an appointment for colonoscopy within 2 weeks in the Trust. The procedure will be carried out by a BSW approved screening colonoscopist.

Screening colonoscopists need to satisfy strict eligibility criteria prior to undergoing a three phase assessment and approval process. Audit data is submitted and scrutinized annually, both for screening colonoscopists and the units they work in (e.g. decontamination audits and risk assessments are carried out by BSW).

Colonoscopy uptake
For every 1000 participants returning a test kit approximately 20 (2%) will be offered a colonoscopy and 18 (90%) will attend for colonoscopy. The appropriateness of colonoscopy in relation to an individual’s risk will be assessed by the screening practitioner who may refer to the lead colonoscopist at the local assessment centre for advice.

It is anticipated that the number of people that will not be suitable for colonoscopy will vary between 1% and 11%.

Colonoscopy results
The cancer detection rate is expected to be approximately 10% of people with positive FOBt results. The polyp detection rate is higher, up to 60% in some areas. There is an additional large proportion of non neoplastic findings, such as diverticular disease, colitis etc.
**Accuracy of colonoscopy**

The sensitivity of colonoscopy i.e. the proportion of abnormalities that are detected by colonoscopy, is thought to be greater than 90%. In a small percentage of participants it does not prove possible to perform a complete colonoscopy: In such a situation the colonoscopist will offer a repeat colonoscopy or alternative radiological investigations.

**Complications of colonoscopy**

Complications are rare but may include heavy bleeding caused by tissue or polyp removal (about a 1 in 150 risk), perforation (1 in 1,000) or death (about 1 in 10,000). Complications are more common as a result of polypectomy.

This small risk has to be set into context with the benefit of a 15% reduction in bowel cancer related deaths expected from the programme.

**Polyp management**

Polyps found during the colonoscopy procedure will normally be removed. If a biopsy is taken, participants will be informed immediately after the procedure. This is confirmed at the time of the test both verbally and in writing and an appointment for one week to discuss the result with the SSP is made. If the result confirms a benign biopsy, participants will be contacted and given the option of cancelling their appointment. They will be recalled for surveillance colonoscopy depending on the classification of polyp. Polyps are classified as low risk, intermediate risk or high risk according to BSG guidelines. The intensity of the follow up reflects the assessed risk in each case as illustrated in figure 2.
The central administration department will co-ordinate the surveillance programme as per British Society of Gastroenterology guidance.

**Screen Detected Cancer**

If bowel cancer is detected at colonoscopy (or via other further investigations), the care of the participant will be handed over to the local colorectal multidisciplinary team (MDT).

Following consultation by the MDT and discussion with the participant, an individual programme of treatment and care will be agreed. Around 8 in 10 people who have bowel cancer detected will be offered surgery to remove the cancer. Research shows that after surgery over 50% of people presenting via the symptomatic service will live for more than five years depending on the stage at diagnosis. On average a higher proportion of those detected by screening would be expected to survive 5 years. Pre or postoperative chemotherapy or radiotherapy may also be offered to patients.
Predicted outcomes of bowel cancer screening in Wales

Exact prediction is difficult to quantify although modelling figures from the English and Scottish programmes has enabled the following estimations.

For every 1000 individuals who complete the FOBt:

- Around 20 have a positive FOBt result and are offered colonoscopy
- Around 18 undergo the colonoscopy procedure*
- Around 8 have no abnormality
- Around 8 have polyps detected at colonoscopy
- Around 2 have bowel cancer detected at colonoscopy

(Based on an uptake rate of 90% for colonoscopy)
The Role of the Specialist Screening Practitioner (SSP)

To provide the highest standard of care for participants of the bowel screening programme a new role has been developed for health care professionals. The Specialist Screening Practitioner will be the first point of contact for participants with a positive FOBt and will guide them through the screening journey. This will include making an assessment of fitness for colonoscopy (using an agreed national proforma), supporting participants by attending the colonoscopy appointment, managing the results handling process and referral to the multi disciplinary team if appropriate. They will work autonomously across the local Trust and in close collaboration with the Welsh Bowel Screening Centre to provide a coordinated and seamless screening service.

Additional training will be given to ensure a high level of specialist knowledge and skills to ensure a quality service is delivered and the participants supported appropriately whatever their screening outcome.

SSPs will work closely with Screening Colonoscopists and refer to the Lead Screening Colonoscopist if a second opinion is required or a person deemed unfit for colonoscopy. SSPs will refer people to the MDT when appropriate in conjunction with the Lead Screening Colonoscopist.

Referral to specialist colleagues for benign disease will follow established pathways and the SSP will ensure this is done appropriately and promptly.

The role of the GP

The intention of the screening programme is to keep the primary care workload to a minimum. However the screening programme has a responsibility to disseminate information about the programme, and once screening has begun, some people receiving invitations and test kits may want the opportunity to discuss the screening process with their GP. Clarification of an individual’s previous health or investigations may necessitate their GP’s involvement.

A retrospective survey and prospective audit of general practice staff following the screening pilot demonstrated a ‘discernible, albeit modest,’ impact on primary care workload. Of particular relevance were increases in paperwork, administration and information provision to patients. (Jepson 2005)

Paperless communication of results is unlikely in the early stages of the programme but is anticipated in the near future.
Programme Evaluation

In screening, evaluation refers to measuring the effect of the programme as a population based service on its cohort. Evaluation measures the screening programme's effect on incidence and mortality and the sensitivity and specificity of the test. Initially the screening programme will appear to increase incidence of bowel cancer as more cancers will be detected, but over time it must demonstrate that it is reducing incidence and mortality rates amongst the target population.

Bowel Screening Wales, in collaboration with the Welsh Cancer Intelligence and Surveillance Unit (WCISU) evaluates the programme by recording and analysing bowel cancer incidence in the eligible population, assigning screening categories and identifying interval cancers.

In addition, evaluation should ensure that the positive predictive value of the screening test is appropriate, that screen-detected cancers are diagnosed at an earlier stage than symptomatic cancers and that the number of interval cancers diagnosed is minimised to demonstrate that the screening test is of sufficient sensitivity.

Public Information

Written information is available to the public and will be posted to participants at the following times:

<table>
<thead>
<tr>
<th>Leaflet</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding Bowel Screening in Wales</td>
<td>General promotion</td>
</tr>
<tr>
<td>Bowel Screening Explained</td>
<td>Sent with initial screening kit</td>
</tr>
<tr>
<td>Unclear Results</td>
<td>For participants with equivocal FOBt tests</td>
</tr>
<tr>
<td>Further Investigations</td>
<td>Sent if a positive result is found</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Following telephone assessment with SSP and acceptance of colonoscopy offer</td>
</tr>
<tr>
<td>Information Following a Colonoscopy (your results 1, 2 &amp; 3)</td>
<td>Post colonoscopy to explain procedure and surveillance programme</td>
</tr>
</tbody>
</table>

Written information has been translated into many other languages and is available on DVD and on the BSW website.
Hard to Reach Groups

The eligible population to be invited for bowel screening is identified from those fully registered with a General Practitioner (GP). However, some groups of the eligible population are at risk of being missed. This is because they may not be registered with a GP or they may not be at their registered address. To ensure that the programme is equitable, other methods need to be in place to identify and invite these people. The groups identified include prisoners; homeless people and rough sleepers; travellers and gypsy travellers; asylum seekers and refugees; patients in long-stay wards or hospitals; residents of care homes; people serving with armed forces and residents in Wales who are temporarily registered with their GP.

It is important to reach these populations as some of them could be at increased risk of bowel cancer for reasons such as poor diet or co-morbidity. It is also recognised that when an intervention is introduced to a population the difference between social economic groups can be increased; as those in higher socioeconomic groups may have a good uptake of the intervention whereas those in the lower socioeconomic groups may not.

A report has been drafted with the aim of identifying the ‘hard to reach’ populations, exploring the barriers to taking part in bowel screening and making recommendations on how to manage bowel screening in these populations. Adapted service models have been drawn up for the different groups. The evidence for this work has come from a review of relevant publications and contact with service providers, strategic leads, information providers and the voluntary sector.

Further Information

Bowel Screening Wales would be very pleased to receive comments or suggestions on this information pack.
For further information and feedback please visit: http://www.bowelscreeningwales.org.uk

Telephone enquiries:
Freephone Helpline 0800 294 3370
This number is for general enquiries and guidance on issues related to the screening process.

Freephone Appointments line 0800 294 3380
This is specifically for appointment related issues including call and recall to the programme.

Postal correspondence to:
The Welsh Bowel Screening Centre
Unit 6
Green Meadow
Llantrisant
CF72 8XT
References


Pathway 1: Invitation to Screening and Faecal Occult Blood Test

Call target population

Recall for FOB in 2 years from date test returned

No response in 6 weeks

Reminder sent and another test kit sent

Test kit not returned within 6 weeks

Send 1st invitation and test kit

No abnormality detected

Test kit returned

Immunochromatographic test kit sent

No response in 6 weeks

IFOB test required

Positive result

Referral

GP and participant informed

Appendix 1: Service Models
Pathway 2  Referral to Assessment

Positive FOB Test
Central Administration Department notified

Results to GP Electronically (phase 2)
Letter sent to participant - asked to contact CAD

Contact made Details confirmed land line and second contact number recorded
No Call within 2 weeks, sent another letter asked to contact CAD

Unable to contact
Repeat phone call
No contact
SSP clinic appointment sent
DNA or Decline

Appointment for telephone assessment with SSP given
No Call within 3 weeks, sent face to face assessment appointment
SSP face to face appointment sent

SSP Assessment – Telephone or clinic appointment
Clinic appointment assessment

Fit for colonoscopy
Colonoscopy offered
Declined
Accepted

Not Fit for colonoscopy
Refer to Pathway 4

Colonscopy appointment date and time agreed.
Refer to Pathway 3

6 monthly letters to participant until 5 years and then 2 year recall to SSP and non responder loop.
G.P. informed and again at 6 and 48 months

6 monthly letters to participant until 5 years and then 2 year recall to SSP and non responder loop
G.P. informed and again at 6 and 48 months
Pathway 3 Colonoscopy

Appointment for Colonoscopy given → DNA → Send another appointment → 2nd DNA → GP informed by series of letters → Letter sent to participant every 6 months for 5 years then 2 yearly recall to SSP

Colonoscopy undertaken →

Colonoscopy Complete → Negate Other Pathology → Cancer suspected → Biopsy or polyp removed →

- Pathology
  - Cancer Confirmed
  - Cancer Excluded
  - Adenoma confirmed
  - Refer to Pathway 6
  - GP & participant informed

- Other Pathology
  - Referral to appropriate specialty

- Cancer suspected
  - Refer to Clinical Nurse Specialist team as per local protocol

- Biopsy or polyp removed
  - Refer to exclusion protocol

- Colonoscopy incomplete
  - Refer to pathway 5

- Inform Participant & G.P.
  - Recall for FOB in 2 years

- Pathology
  - Benign
    - Refer to MDT
Pathway 4  Not Fit for Colonoscopy

Positive FOBt
Not fit for colonoscopy

Assessed by Screening Colonoscopist

Suitable for radiological investigations
Not suitable for radiological investigations

Individual management plan agreed

CT colonography or barium enema offered according to local protocol

Decline  Accept

Radiology appointment agreed

CT colonography or Ba enema undertaken
DNA

Send another appointment  2nd DNA  GP informed
Series of letters to participant

Consider repeat once only 2nd incomplete procedure

Refer to screening colonoscopist for management decision

Complete  Incomplete

Participant & GP informed
Recall for FOBt in 2 years

Negative  Other Pathology suspected
Adenoma suspected  Cancer suspected

Refer to screening colonoscopist for management decision

Inform Participant & G.P.
**Pathway 5 Incomplete Colonoscopy**

Colonoscopy undertaken

- Refer to Pathway 3
- Colonoscopy complete
- 2nd incomplete
  - Screening colonoscopist decides individual management plan
  - Colonoscopy Incomplete
    - Repeat colonoscopy considered
      - Not suitable for repeat colonoscopy
        - Refer to Pathway 4
      - Suitable for repeat colonoscopy
        - Refer to Pathway 3
**Pathway 7  Referral to Multidisciplinary Teams**

- **Colonoscopy**
  - Obvious cancer
  - Biopsy taken
  - Polyp removed
  - Refer to CNS team at time of colonoscopy
  - Histopathology
    - Cancer confirmed
    - Other pathology
      - Manage according to local protocol as for symptomatic patients
        - SSP and screening colonoscopist informed
          - SSP attends MDT meeting
        - Presented to colorectal MDT by CNS team
            - SSP attends MDT meeting
  - Result to screening colonoscopist
    -Copied to SSP
    - Discuss result-agree management
      - Cancer
        - Refer to MDT coordinator-assigned to a named consultant
      - Other Pathology
        - Refer to relevant specialty
          - Local mechanism for discussion of difficult cases
            - Case presented to MDT by screening colonoscopist
              - SSP present