Trust Policy	NHS Worcestershire Acute Hospitals NHS Trust

County Wide Process Vetting of Endoscopy Referrals to WAHT Units

Department / Service:	Endoscopy Countywide Services
Originator:	Julie Mathew – Advanced Nurse Practitioner Karen Macpherson – JAG/Governance Lead
Accountable Director:	Mr Richard Lovegrove
Approved by:	Endoscopy Directorate Group
Approved by Medicines Safety Committee: *Where medicines included in guideline*	N/A
Date of approval:	6th December 2023
First Revision Due: **This is the most current document and should be used until a revised version is in place**	6th December 2026
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Endoscopy Countywide Services
Target staff categories	All Referring Clinicians & Endoscopists

Policy Overview:
This policy provides an overview to the vetting process undertaken when referring to Endoscopy for an Endoscopic procedure. This process details guidelines and rules for referring patients in line with JAG standards.

Key amendments to this document

Date	Amendment	Approved by:
Sept 2023	Review and Update	*Endoscopy Directorate group*

Contents page: **Page:**

Appendices:

Supporting Documents

1. Introduction

- This document aims to inform clinicians of the vetting process to be undertaken upon receipt on a referral and also will provide a systemic review of the processes involved in vetting of patients prior to repeat endoscopy for previous pathology encountered or those patients who have a genetic predisposition for cancer.
- To ensure that patients follow the correct pathway and guidelines and receive their endoscopy in a safe and timely manner.
- The process aims to ensure that patients are referred, clerically and clinically vetted and booked accordingly.
- The vetting of surveillance referrals meets requirements as stated by the Global Rating Scale documentation in section 5 - Appropriateness (please use this link to go to the JAG GRS standards) https://www.thejag.org.uk/Downloads/JAG/Accreditation%20-%20Global%20Rating%20Scale%20(GRS)/Guidance%20-%20GRS%20standards%20UK%202023.pdf

2. Scope of this document

This process applies to all staff involved in countywide Endoscopy services: Alexandra Hospital, Redditch, Evesham Community Hospital, Kidderminster Treatment Centre and Worcestershire Royal Hospital, Worcester, Malvern Community Hospital.

This document relates to all procedures undertaken in the Endoscopy Units and specific designated areas, with the exception of PEG and stent insertion, and EUS.

This policy applies to all staff involved who refer patients for Endoscopy procedures (ie; junior doctors, non-endoscopist Consultants, GP's).

This policy supports standards set out by JAG and aims to continuously achieve high standards

3. Definitions

PEG	Percutaneous Enteral Gastrostomy (feeding tube)
Non-Endoscopist	Clinician who does not perform Endoscopy procedures within WAHT Hospitals
JAG	Joint Advisory Group
GRS	Global Rating Scale
GI's	Gastrointestinal
Upper Endoscopy	Endoscopy procedure that looks from the throat to the second part of the duodenum
OGD	Gastroscopy – Endoscopy procedure that looks into the stomach
Barrett's Oesophagus	Condition whereby the stomach lining grows into the oesophagus
Varices	Dilated vein
Lower Bowel	Endoscopy procedures that looks into the large bowel

Endoscopy	
ERCP	Endoscopic Retrograde Cholangio-Pancreatography
EUS	Endoscopic Ultra Sound

4. Responsibility and Duties:

- **Clinical Director for Endoscopy**
  Overall responsibility for the clinical aspects of the vetting process.

- **General Manager for Endoscopy**
  Overall responsibility for the non-clinical aspects of the vetting process

- **All Referring Clinicians**
  Responsibility to understand and adhere to the vetting process.

- **All Vetting Clinicians**
  Responsibility to understand and adhere to the vetting process and Endoscopy guidelines.
- **All Pre-Assessment Staff**
  Responsibility to understand when the referrals have been vetted appropriately and to escalate accordingly when there is no evidence of vetting being carried out.

Information regarding failure to comply with a process must be reported to the line manager and, where it is appropriate, report this using the incident reporting system. Audits are carried out of the vetting process annually.

5. Policy detail:

GP/ non Endoscopist/Trainee GI's referrals for Diagnostic Procedures:

- All In-Patient referrals for Upper and Lower GI procedures are vetted by the on-call gastroenterologist.
- All Urgent Suspected Upper GI Referrals go to the 2ww office and are booked directly (not triaged)
- All Colorectal Urgent Suspected referrals go to Colorectal Specialist Nursing Team for triage
- Flexible Sigmoidoscopy Pathway referrals are sent direct to the endoscopy Booking team, the referral is checked for accuracy and then allocated to the clinical endoscopist team to triage. The Booking team will then be told to book if appropriate. If not to be booked, then a letter is sent to the Patient and GP to explain.

Surveillance / Repeat OGD's:

- A list of patients from the relevant PTL is extracted and vetted as above. Also, any repeat procedures requested at the time of index procedure are identified and given to the booking team for re-booking immediately (if due within 12-weeks) or placing onto the relevant waiting list.
- All patients will be notified that their records are being reviewed 2 months prior to their due date (Appendix C)
- The vetting process is described in appendix D
- The booking staff and designated endoscopist will follow the Upper GI Vetting Form (Appendix E)
- Once decision to proceed to procedure has been made, these patients will be contacted via telephone by the admin team to book a date for the procedure (and pre-assessment if the patient requires colonoscopy of flexi-sig with bowel prep).
- Once patient has agreed their appointment date a letter will be sent to confirm.
- If no procedure required, then a letter will be sent to patient and GP explaining this.

Surveillance / Repeat Colonoscopy/Flexible Sigmoidoscopy:

- The Surveillance report will be extracted from the PTL either by a member of the booking team or the clinical endoscopist, also repeat procedures are identified via the red tray process and actioned accordingly.
- All records reviewed 2 months prior to their due date.
- The vetting process is described in appendix F
- The booking staff and designated endoscopist will follow the Lower GI Vetting Form (Appendix G)
- A letter notifying patients (Appendix E) will be sent following clinical and clerical vetting of the patients notes if there are any changes to the level of surveillance.

ERCP's:

- Referrals for inpatient ERCP are discussed 'doctor to doctor' with an Endoscopist that currently performs the procedure and the referral form should be marked to record that the discussion has taken place, dated and signed with a legible signature and contact details.
- For Outpatient ERCP the referring Consultant's secretary will email a copy of any relevant clinic letter to tally up with the referral form.
- Should WVT (Wye Valley Trust) require assistance with accommodating an inpatient ERCP, the referring Consultant should send an emailed request through to wah-tr.WRH-EndoscopyBookings@nhs.net; these will be given to the Sister to facilitate clinical review (vetting) by the ERCPist. Decision will be made to decline / accept the referral and prioritise on the forthcoming inpatient list(s).

EUS:

- All EUS referrals are discussed at the weekly Upper GI MDT meeting.

PEG/STENT/GI Bleed referrals are not covered by this policy as there are separate procedures to follow.

Direct access upper GI and Lower GI Referrals:

- All referrals come through to RAS.
- All Upper GI referrals are triaged are by the gastroenterologist, and the lower GI referrals are triaged by a Colo-Rectal Surgeon.
- A decision will be made at that time based on the details on the referral form what level of urgency is required for the procedure.

6. Implementation

6.1 Plan for implementation

- Circulate to all clinicians
- Inform booking staff of the vetting process
- Ensure rota set up for clinicians to vet referrals

6.2 Dissemination

- The Policy will be placed on the Trust's Endoscopy Intranet page and all staff made aware through the use of the Trust Daily Brief. The process will be discussed at Endoscopy Unit team meetings and Directorate meetings.

6.3 Training and awareness

- Ensure that the Endoscopy referral forms are accessible to all through the Endoscopy Intranet page and guidance is documented for all referring clinicians to follow.

7. Monitoring and compliance

This process will be reviewed by completing a "snap-shot" audit of 20 patients per month. Looking at completion of the referral form, that the referral was accepted and that the patient has been vetted appropriately and added to the appropriate PTL/ waiting list.

The NHSLA requirements are –

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHSLA Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether or not the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

The table below should help to detail the 'Who, What, Where and How' for the monitoring of this Policy.

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	These are the 'key' parts of the process that we are relying on to manage risk. We may not be able to monitor every part of the process, but we MUST monitor the key elements, otherwise we won't know whether we are keeping patients, visitors and/or staff safe.	What are we going to do to make sure the key parts of the process we have identified are being followed? (Some techniques to consider are; audits, spot-checks, analysis of incident trends, monitoring of attendance at training.)	Be realistic. Set achievable frequencies. Use terms such as '10 times a year' instead of 'monthly'.	Who is responsible for the check? Is it listed in the 'duties' section of the Policy? Is it in the job description?	Who will receive the monitoring results? Where this is a committee the committee's specific responsibility for monitoring the process must be described within its terms of reference.	Use terms such as '10 times a year' instead of 'monthly'.

8. Policy Review

This document will be reviewed every two years; the responsibility is that of the JAG/Governance Lead for endoscopy and nurse practitioner

9. References:

	Code:
British Society of Gastroenterology	
NICE guidance	
JAG GRS	

10. Background

10.1 Equality requirements

This policy will not have any impact either positive or negative on any patients' equality or diversity needs.

10.2 Financial risk assessment

This policy does not have a financial impact.

10.3 Consultation

The same staff will be involved in the consultation process as in the contribution list The policy will be sent out for comment and once ready for approval will be discussed and approved at the monthly Endoscopy Directorate Meeting on the Governance agenda.

10.4 Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Mr Lovegrove
Mr Lake
Dr Gee
Dr Hudson
Dr Elagib
Dr Cheung
Dr Rees
Dr Smith
Lynne Mazzocchi
Gina Gill
Julie Mathew
Phil Brown
Rachel Foley
Karen Macpherson

This key document has been circulated to the chair(s) of the following committees / groups for comments;

Committee
Endoscopy Directorate Meeting

10.5 Approval Process

The internal process for this document agreement is via the Endoscopy Directorate Meeting .

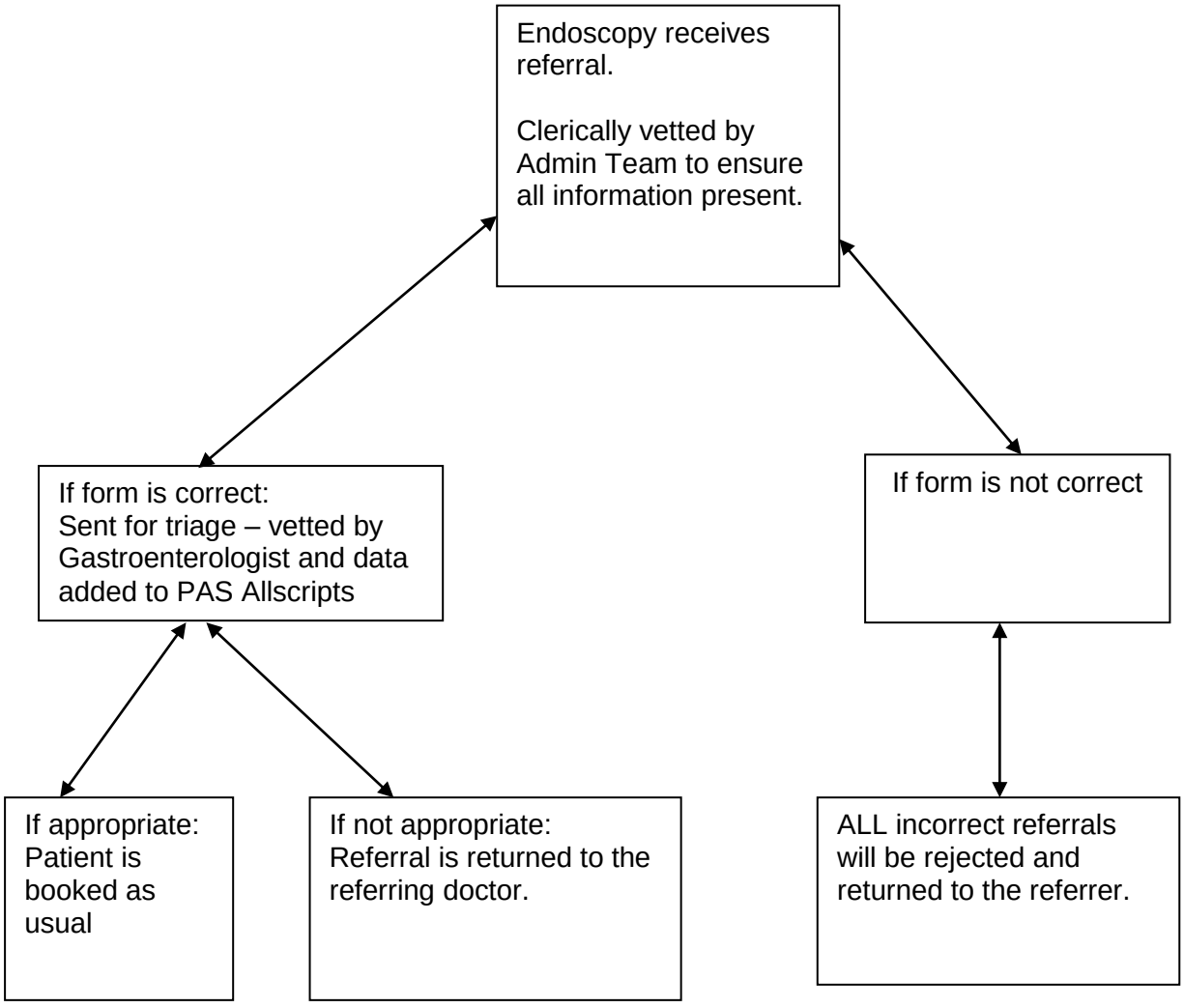
10.6 Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

Date	Amendment	By:
09/23	All content and appendices reviewed and updated	JM & KM

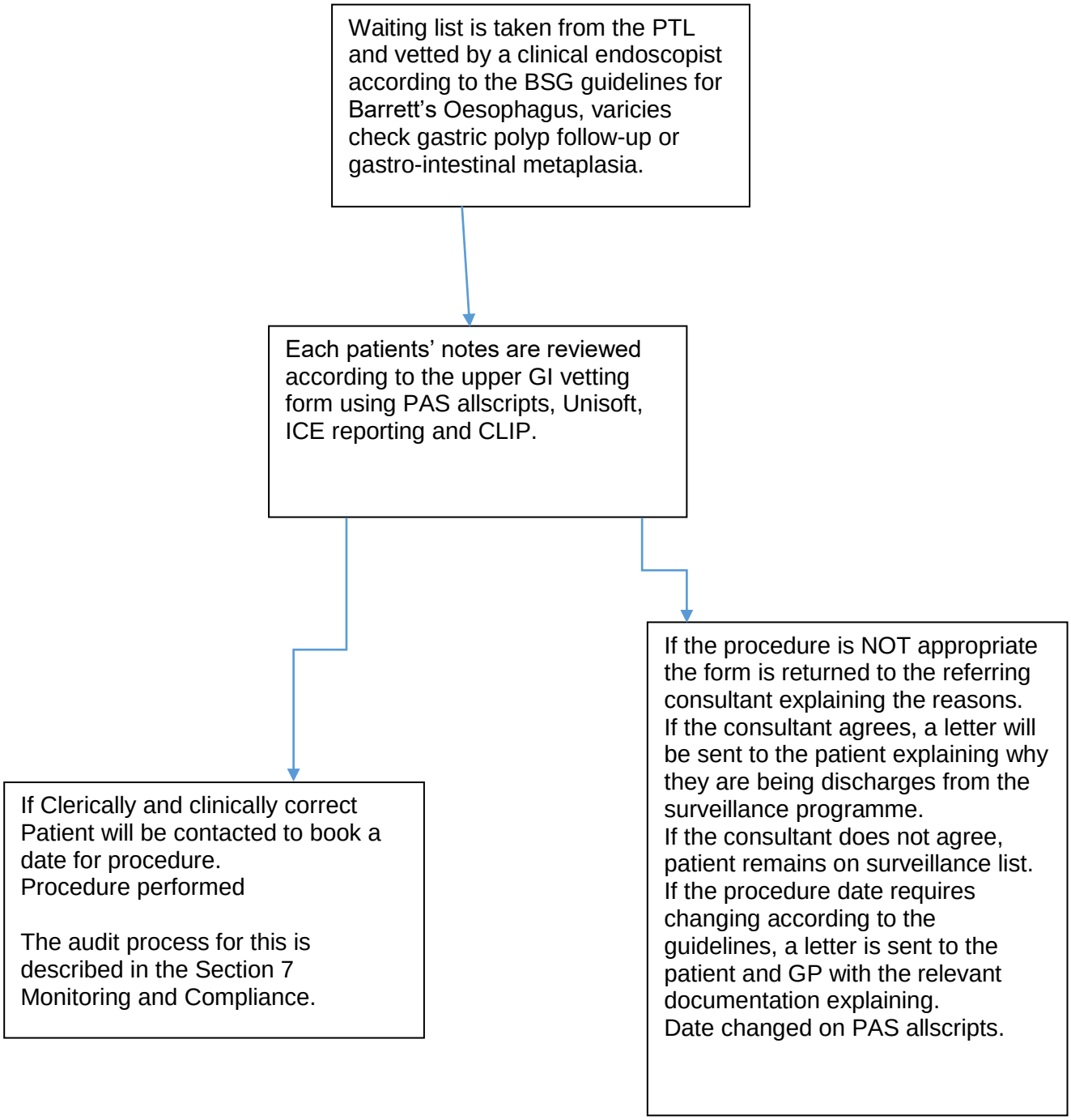
APPENDIX A

Non Endoscopist Referrals Algorithm:
Please note that colonoscopy referrals should be discussed with the on call gastroenterologist. All referrals will be triaged by the on call gastroenterologist and the urgency will be determined at triage.



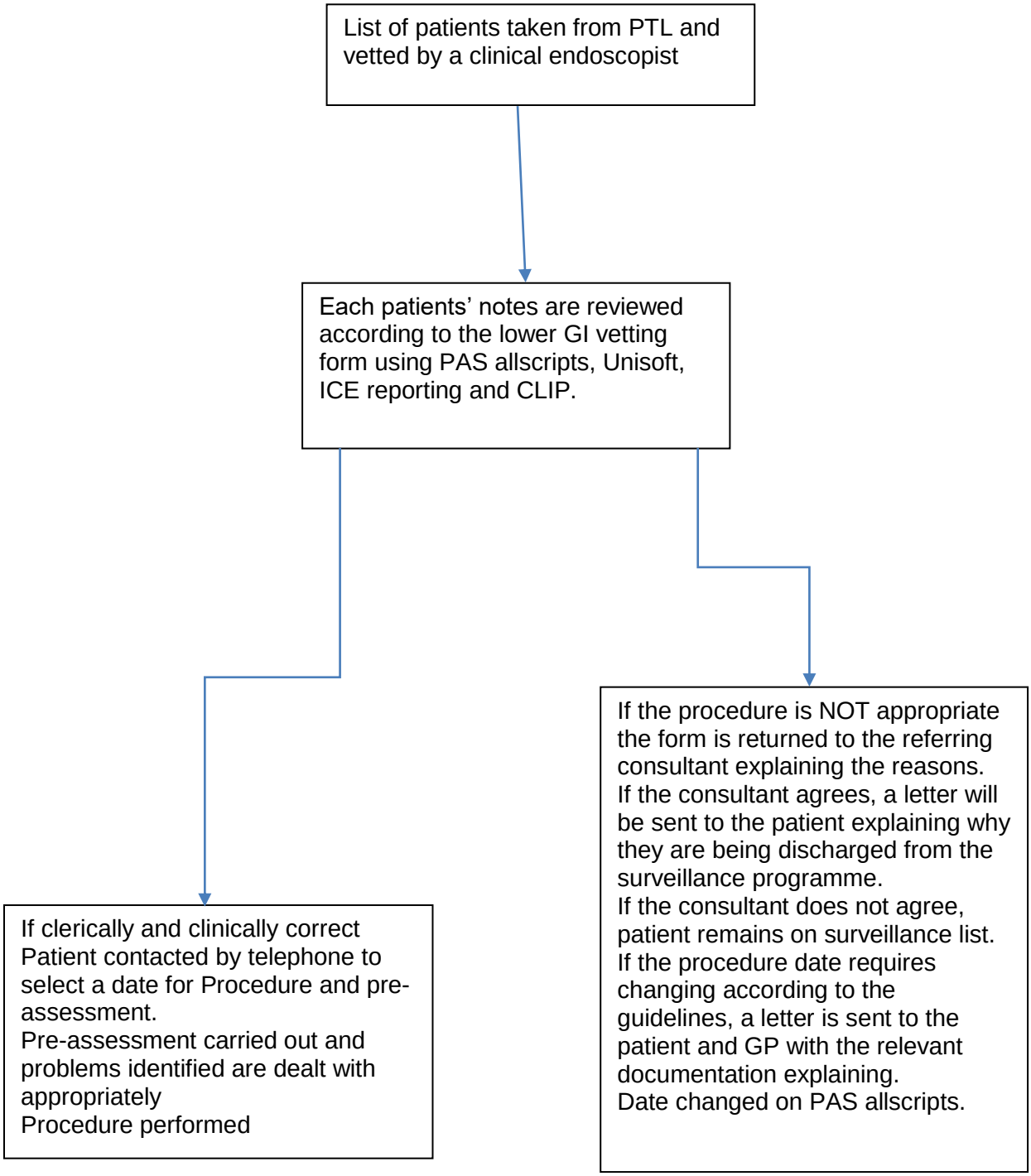
APPENDIX B

Process for Vetting Upper GI Surveillance Procedures Algorithm:



APPENDIX C

Process for Vetting of Lower GI Procedures Algorithm:



APPENDIX D - Upper GI Vetting Form

Recommended pathway for Upper GI Surveillance

Pt ID:
Pt Name and age:
Referring consultant:
Vetted by and date:

Does the patient require an interpreter Yes No

Patient information:

Insulin dependent diabetic Yes No
Non-insulin diabetic Yes No
Is the patient taking any anti-coagulant/platelets Yes No
If warfarin date of last INR…….. INR result……. If not within 7 days, please ask patient to repeat at surgery. The patient does not need to stop prior to endoscopy unless INR is over 3 at which point consult referring consultant regarding result and further management

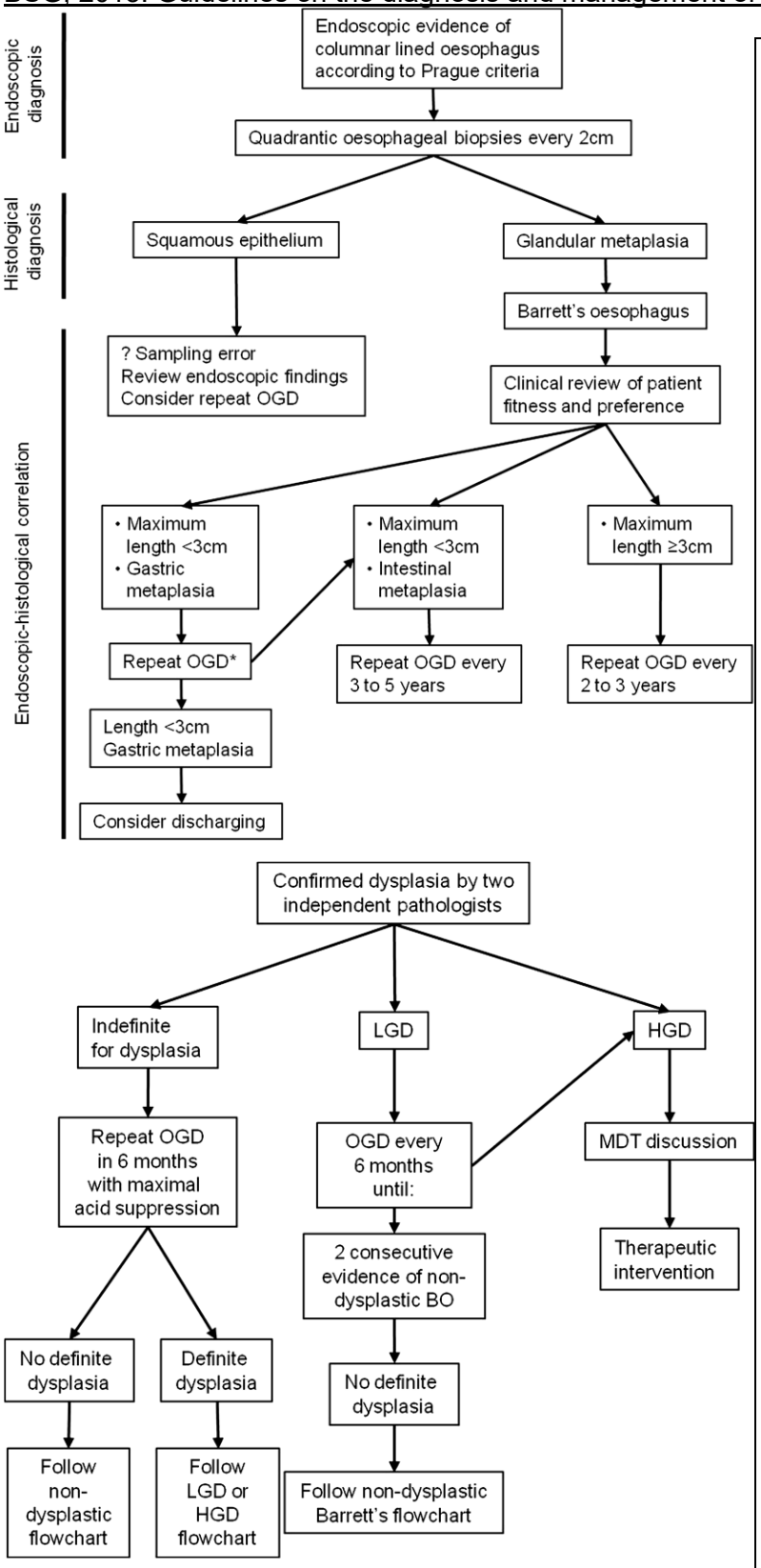
Date gastroscopy required:

Barrett's letter required yes no

Repeat 2 yrs.
Repeat 3yrs
To come off as under 1cm
Gastric metaplasia – discharge

Comments:

BSG, 2013. Guidelines on the diagnosis and management of Barrett's oesophagus



Date of last scope
……

Histology result:
……

Less than 3cm with gastric metaplasia – Re-scope 6 – 8 weeks
If gastric metaplasia – discharge

3 cm or less – re-scope 3 yrs.

>3 cm repeat scope 2 years

If less than 1cm no surveillance required

No dysplasia
LGD – 6 monthly until 2 consecutive non dysplastic mucosa noted on biopsies
HGD - MDT
Date due……ASAP……
…….

Varices Surveillance, BSG, 2000

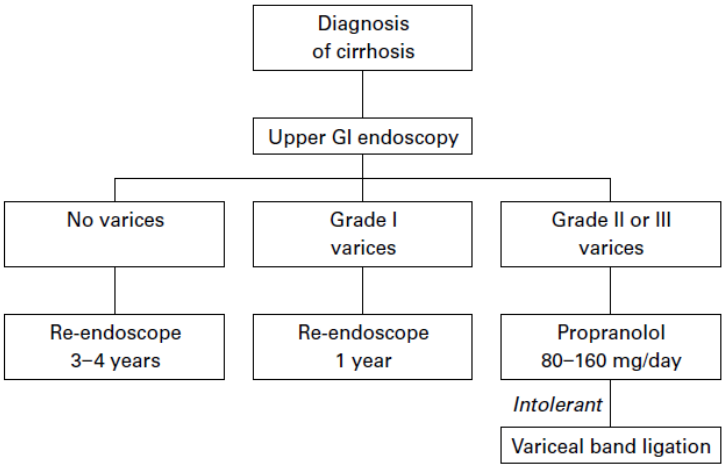


Figure 1 Proposed algorithm for surveillance for varices and primary prophylaxis.

Date of last OGD……
No Varices
Grade I varices
Grade II or III varices

Date due repeat OGD……..

Gastric polyps, BSG, 2010

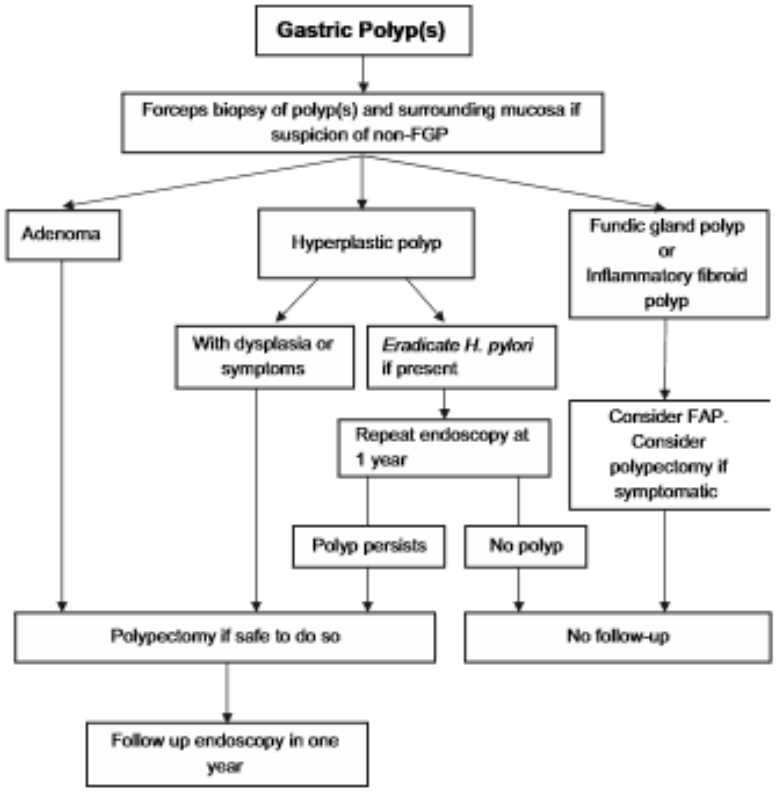


Figure 1 Algorithm for the management of gastric polyps. FAP, familial adenomatous polyposis.

Date of last OGD……..
Adenoma
Polypectomy
Hyperplastic polyp
Polypectomy
Eradicate H pylori
Fundi cystic polyp/fibroid polyp
Repeat endoscopy 1 year
Discharge
Due next OGD……

Intestinal metaplasia

If intestinal metaplasia suspected – 4 biopsies from proximal, distal, lesser curve and greater curve stomach in separate pots.
If extensive metaplasia – 3 yearly scope is required
If mild or moderate intestinal metaplasia or atrophy only found in the antrum – no surveillance is required
Dysplasia –
LGD – re scope in 12 months
HGD – re scope in 6 months

Family history

Family History of Gastric/Oesophageal Cancer below the age of 40 yrs. or multiple members of family requires referral to Genetic Screening team at Birmingham. In the first instance, H pylori screening should be undertaken and eradication if positive. There is no current National guidance regarding genetic screening or interval endoscopy for those patients with a family history of oesophageal or gastric carcinoma.

APPENDIX E

Recommended pathway for Colonoscopy Surveillance

Pt ID

Referring Consultant…… Vetted by……

Signature…….
Date……..

Does the patient require admission for the procedure? Yes / No

Does the patient require an interpreter? Yes / No

If the patient is on anticoagulants/antiplatelet ☐ Please refer to the referring consultant for further advice with the checklist

Is the patient is diabetic ☐ Please refer to instructions in the information document

Prescribing of bowel preparation:

Blood test requested Yes ☐ Date requested …… No ☐

eGFR ☐ LFT ☐ FBC ☐

If patient blood tests are abnormal please refer to referring consultant for further management

Patients last GFR …….. Date……..

Have these checks been made:

ACEi/ARB	Y / N	Safe to stop for 72hrs?	Y / N
Diuretics	Y / N	Safe to stop for 24hrs?	Y / N
NSAIDs	Y / N	Safe to stop for 72hrs?	Y / N

Clinician to sign below to agree that:
Oral bowel preparation (Moviprep/Plenvu) ☐ (under PGD DS/END/06) Rectal Enema ☐ is to be dispensed/supplied

Clinician Signature……. Print Name…….
Date…….

Checked by/dispensed by…… (Pharmacy/Nurse signature)
Date…….

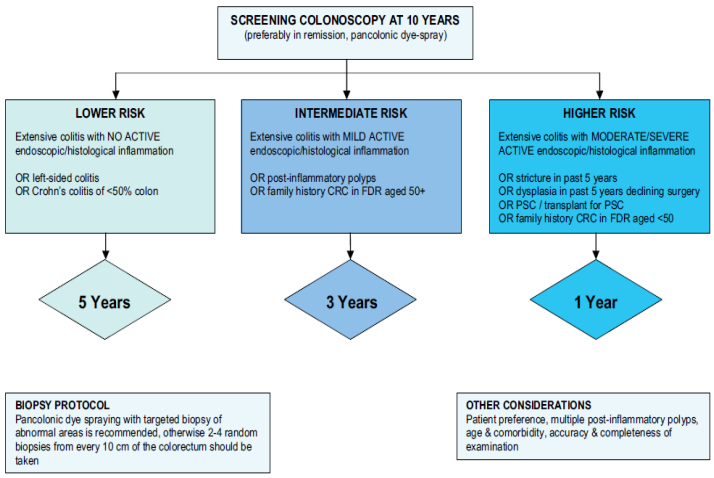
Date colonoscopy required…….. Pre assessment required……..

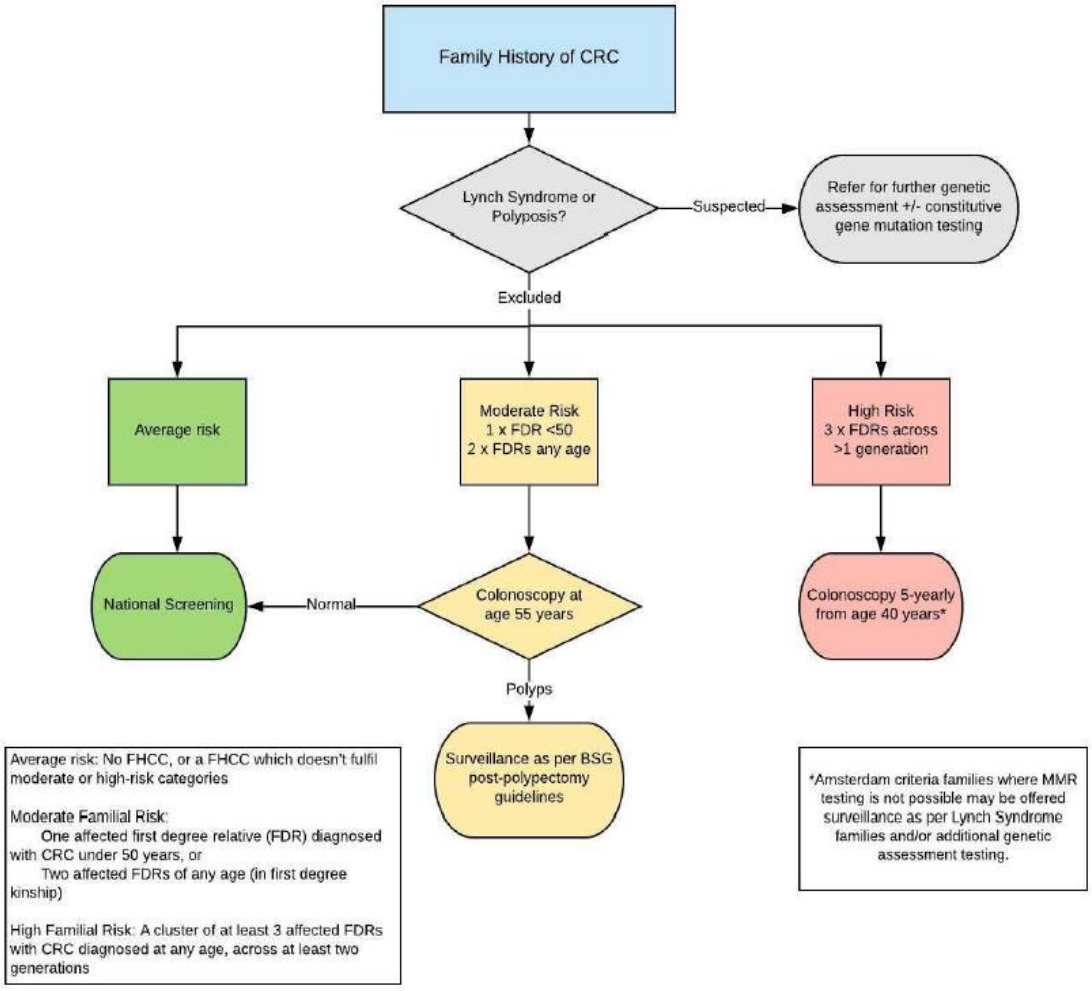
Letter written with change of date……. Yes / No

PAS changed …… Yes / No

Disease Groups

Colorectal cancer Post-CRC-resection patients should undergo a 1-year clearance colonoscopy, then a surveillance colonoscopy after 3 more years	Date/type of resection…… …….. Date of last endoscopy…… ……
Polyps The key recommendations are that the high-risk criteria for future colorectal cancer (CRC) following polypectomy comprise EITHER: ○ 2 or more premalignant polyps including at least one advanced colorectal polyp (defined as a serrated polyp of at least 10mm in size or containing any grade of dysplasia, or an adenoma of at least 10mm in size or containing high-grade dysplasia); OR ○ 5 or more premalignant polyps This cohort should undergo a one-off surveillance colonoscopy at 3 years. No surveillance if life-expectancy <10y or if older than about 75y	Date of last colon…… …… No of polyps…… …… Size of largest polyp…… …… Next colonoscopy due…… ……..… To be removed from surveillance…… ……...
EMR Complete excision – repeat 3 yrs Incomplete excision – repeat at 6 months, then 1 year	Date scoped…… …… Complete excision…… Incomplete excision……..… 3 mths …… 1 yr. …… Date required …….……

IBD  	Total or left sided colitis?..... Date of last colonoscopy…… ……. Histology results……... Next due colonoscopy……..…… ……
Acromegaly Colonoscopy at 40 yrs. and then 5 yearly Family Groups FAP (Familial adenomatous polyposis) and variants Juvenile polyposis and Peutz-Jegher - Refer to genetics'	Date of last colonoscopy…… ……. Next due colonoscopy…… ……
At risk HNPCC or more 2 FDR - Refer to clinical geneticist Also documented MMR gene carriers Two yearly colonoscopy up to the year of 75 years No OGD recommended now unless on clinical trial	Geneticist recommendations…… …… Date of last colonoscopy…… …… Next due colonoscopy…… ……..
On advice of clinical geneticists for criteria not listed above	Geneticist recommendations…… …… Next due colonoscopy…… ……



Family history:

Mother ☐ Age of diagnosis…… Father ☐ Age of diagnosis……

Siblings ☐ Age of diagnosis…… Aunt/Uncle ☐ Age of diagnosis ……

Grandparent ☐ Age of diagnosis……

BCSP **Colonoscopy at 55 yrs.** **Colonoscopy 5 yearly from 40 yrs.**

If high risk category, please refer to genetic screening

If referred to genetic screening please change the date to 6-month review on PAS All Scripts for the patient to enable review of letter on CLIP. If no letter is present after 6 months, then send another form to the patient and inform them that if no correspondence has been made with Birmingham Genetic Screening team then their name may be taken off the surveillance programme.

APPENDIX F -

NHS Worcestershire Acute Hospitals NHS Trust

Endoscopy Unit
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Tel: 01905 763333

Date: <Todays Date>
NHS No: <Patient: NHS Number>
Hospital No: <Patient: Hospital Number>

<Patient: Salutation> <Patient: Name Initials> <Patient: Surname>
<Patient: Address>

Dear <Patient: Salutation> <Patient: Surname>

I am writing to inform you that following a review of your notes, a discussion with your referring Consultant and previous endoscopy; the National guidelines for your surveillance colonoscopy recommend that we re-scope you in […add date…] not […Add date…] as previously discussed.
In the interim time if you should develop any problems such as unexplained weight loss, altered bowel habit (unusual for you) or passing of blood via the rectum, then please contact your GP surgery and we would be more than happy to see you before this date.
Many thanks for your consideration in this matter
Yours sincerely

Dictated but not signed

cc. <GP: Surgery>

APPENDIX G -

Worcestershire NHS
Acute Hospitals NHS Trust

Endoscopy Unit
Alexandra Hospital
Woodrow Drive
Redditch
B98 7UB

Tel: 01527 503030

Date: <Todays Date>
NHS No: <Patient: NHS Number>
Hospital No: <Patient: Hospital Number>

<Patient: Salutation> <Patient: Name Initials> <Patient: Surname>
<Patient: Address>

Dear <Patient: Salutation> <Patient: Surname>

Re: Surveillance colonoscopy guideline change

Since your last colonoscopy, the British Society of Gastroenterologists, in conjunction with the Association of Coloproctology of Great Britain and Ireland and the United Kingdom's Cancer Genetics Group, have updated the guidelines for who requires surveillance colonoscopy, and when, based on their family history or previous endoscopic screening. This guideline is being implemented nationally, and Worcestershire Acute Hospitals NHS Trust is in the process of checking all patients awaiting a surveillance colonoscopy against the new guidance.

As part of this, we have reviewed your previous colonoscopy and biopsy results, along with any information we hold on your family history or advice from a geneticist and are pleased to let you know that you no longer require any further surveillance colonoscopy. If you are of an age where you would receive the Bowel Cancer Screening Programme kits (currently age 56 – 75), then we would recommend that you complete these when sent them. If small amounts of blood are detected with this, then a colonoscopy will be arranged for you.

If you believe that we may not hold up-to-date information regarding your family history, please let us know so we can reassess this and advise you accordingly.

If you develop any new change in your bowel habit, rectal bleeding or weight loss, then please follow this up with your GP so they can assess you.

We have included a copy of the guideline summary at the end of this letter.

Yours sincerely

Dictated but not signed
Mr Richard E Lovegrove MD FRCS
Clinical Director for Endoscopy
cc. <GP: Surgery>

Guidelines for the management of hereditary colorectal cancer from the British Society of Gastroenterology (BSG)/ Association of Coloproctologists of Great Britain and Ireland (ACPGBI)/ United Kingdom Cancer Genetics Group (UKCGG)

Lay summary

What do these guidelines cover?

Bowel cancer is a common disease which will affect approximately 1 in 20 people in their lifetime. In the United Kingdom there is a national screening programme available for the whole population at a certain age (beginning in people in their 50s or 60s depending on where they live). This is usually a stool test perhaps followed by a colonoscopy.

In some people there are genetic ('hereditary') factors which may increase this lifetime risk of cancer. This may include those with a family history of bowel cancer, or those with genetic conditions which increase the risk of cancer of the gut. In some people with increased hereditary risk of cancer, we would suggest additional check-ups, surgical procedures, genetic testing or other interventions including medications or lifestyle advice.

A colonoscopy test uses a thin flexible tube with a tiny camera on the end to look inside your bowel. This test can find bowel cancer, or polyps (pre-cancerous growths) which can usually be removed to lower the risk of bowel cancer.

We address the issue of person-specific care (sometimes called 'personalised' care) in such individuals at increased risk of cancer of the gut.

This includes the choice of surgical procedures, made between clinicians and patients, which may be different from those without genetic risk factors for bowel cancer.

Gene testing for inherited risk factors for cancer is usually performed after some counselling, followed by a blood test. In this guideline we discuss the best ways to improve identification of people who might have increased genetic risk of bowel cancer, in order to prevent cancer, or better treat those with cancer who also have genetic risk factors.

These guidelines are primarily aimed at healthcare professionals and address:

- Who should have surveillance?
- When should surveillance take place?
- What else can we do to prevent cancer?
- What kind of surgery should we perform in people with hereditary cancer risk?
- Who is eligible for gene testing, and what kind of testing should we perform?

These guidelines were written by the British Society of Gastroenterology (BSG), the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the United Kingdom Cancer Genetics Group (UKCGG).

Common questions that patients and their relatives ask are outlined below.

If I have a family history of bowel cancer, do I need a colonoscopy?
It is not unusual to have a family history of bowel cancer. For most people the usual screening offered for those at average lifetime risk is adequate as a means of surveillance. However, if a close relative was diagnosed under age 50 years, or if you have more than one close relative with bowel cancer, you may benefit from additional tests and/or procedures.
What is the purpose of surveillance?
The main purpose of surveillance is to find and remove polyps so that they are prevented from potentially developing into cancer in the future. If a cancer does occur, surveillance may also find it at an earlier stage when it is easier to cure.
Who can I ask about genetic testing?
You can talk to your GP about whether you should be referred to a specialist for genetic testing. It can be helpful to have genetic testing, but it is not always appropriate. With scientific advances more genetic testing is possible however.
Why have these guidelines on surveillance been updated?
New evidence has allowed medical professionals to improve the previous guidelines which were published a decade ago. New genetic tests are available which help us make decisions about how we may prevent cancer. Moreover, since the last guidance, national bowel screening has been introduced which provides a useful check-up for low-risk people. The updated guidelines aim to make surveillance, surgery, genetic testing and other more personalised. This ensures that such procedures or tests are recommended for people who need it, and not recommended to those who do not. Therefore, for some people the need for and timing of surveillance colonoscopies has altered in this updated guidance.

APPENDIX H –

Worcestershire NHS
Acute Hospitals NHS Trust

Endoscopy Unit
Alexandra Hospital
Woodrow Drive
Redditch
B98 7UB

Tel: 01527 503030

Date: <Todays Date>
NHS No: <Patient: NHS Number>
Hospital No: <Patient: Hospital Number>

<Patient: Salutation> <Patient: Name Initials> <Patient: Surname>
<Patient: Address>

Dear <Patient: Salutation> <Patient: Surname>

Re: Surveillance colonoscopy guideline change

Since your last colonoscopy, the British Society of Gastroenterologists, in conjunction with the Association of Coloproctology of Great Britain and Ireland and Public Health England, have updated the guidelines for who requires surveillance colonoscopy, and when, following a previous bowel cancer operation or having had polyps removed. This guideline is being implemented nationally, and Worcestershire Acute Hospitals NHS Trust is in the process of checking all patients awaiting a surveillance colonoscopy against the new guidance.

As part of this, we have reviewed your previous colonoscopy and biopsy results and are pleased to let you know that you no longer require any further surveillance colonoscopy. If you are of an age where you would receive the Bowel Cancer Screening Programme kits (currently age 56 – 75), then we would recommend that you complete these when sent them. If small amounts of blood are detected with this, then a colonoscopy will be arranged for you.

If you develop any new change in your bowel habit, rectal bleeding or weight loss, then please follow this up with your GP so they can assess you.

We have included a copy of the guideline summary at the end of this letter.

Yours sincerely
Dictated but not signed
Mr Richard E Lovegrove MD FRCS
Clinical Director for Endoscopy

cc. <GP: Surgery>

BSG/ACPGBI/PHE Post-polypectomy and post-colorectal cancer resection surveillance guidelines

Lay summary

What do these guidelines cover?
A colonoscopy test uses a thin flexible tube with a tiny camera on the end to look inside your bowel. This test can find bowel cancer, and also polyps (non-cancerous growths) which can usually be removed to lower the risk of bowel cancer. These updated guidelines consider the use of surveillance ("check-up") colonoscopies and bowel imaging in people who have had either bowel polyps or a bowel cancer removed.

These guidelines are primarily aimed at healthcare professionals and address:

- Who should have surveillance?
- When should surveillance take place?
- When can surveillance be stopped?

Some people and their families are at particularly high risk of developing polyps due to genetic (inherited) conditions: this guidance does not cover these people – separate guidelines have been published for them.

These guidelines were written by the British Society of Gastroenterology (BSG), the Association of Coloproctology of Great Britain and Ireland (ACPGBI) and the English Bowel Cancer Screening Programme (Public Health England [PHE]). They are also supported by NHS England (NHSE).

Common questions that patients and their relatives ask are outlined below.

What is the purpose of surveillance?
The purpose of surveillance is to find and remove any new polyps so that they are prevented from potentially developing into cancer in the future. If a cancer does occur, surveillance may also find it at an earlier stage when it is easier to cure.

Why have these guidelines on surveillance been updated?
New evidence has allowed medical professionals to improve the previous guidelines. Moreover, since the last guidance, national bowel screening has been introduced which provides a useful check-up for low-risk people. The updated guidelines aim to make surveillance more personalised, ensuring it is recommended for people who need it, and not recommended to those who do not.

This means that the need for and timing of surveillance colonoscopies has altered in this updated guidance.

If I have had polyps removed during a colonoscopy, will I need a surveillance colonoscopy in the future?
Not always. Bowel cancer usually develops from polyps, which is why specialists remove polyps during colonoscopy. Often this is all that is required, but in some people, new polyps can grow in the future. These guidelines tell doctors which people are at risk of new polyps and should have future surveillance colonoscopies.

If you do not need surveillance colonoscopies, we still encourage you to take part in the national Bowel Cancer Screening Programme as/when you are invited (currently from age 50 in Scotland

and 60 in Wales, Northern Ireland and England, although Wales and England have made commitments to lower this age to 50 in line with Scotland).

Why do some people with polyps NOT need surveillance?
The two main reasons for this are:

- Not all people who have had polyps removed are at increased risk of developing cancer;
- Having a colonoscopy does have some potential risks. For some people, this risk outweighs the potential benefit.

These guidelines help doctors to decide what is right for each patient.

How often will I need to have surveillance colonoscopies?
This will depend on your individual circumstances, and your doctor will explain this to you using these guidelines.

- Recent evidence has shown that in many cases the intervals previously used for colonoscopy surveillance were too short (i.e. patients were asked to have a colonoscopy too frequently). In most cases, we now recommend an interval of three years;
- Evidence shows that with high quality colonoscopy using the latest techniques, once the bowel is cleared of polyps there is only a small chance of developing further high-risk polyps that may turn into cancers. Therefore, in most cases a single follow-up colonoscopy will be all that is needed.

Why stop at around 75 years of age?

- For a patient around the age of 75, once the bowel has been cleared of polyps they are very unlikely to benefit from further surveillance colonoscopy;
- This is because, even if a new polyp occurs, it usually takes at least ten years for it to grow from a small polyp into a high-risk polyp or cancer;
- Although colonoscopy is usually safe, the risk of a complication of the test itself (e.g. bleeding) or an associated event (e.g. stroke, heart or kidney problem) occurring after a colonoscopy increases significantly in patients over the age of 75;
- Every patient should be able to discuss their own case with their doctor to weigh-up the associated risks and potential benefits of having a further colonoscopy.

APPENDIX I –

NHS Worcestershire Acute Hospitals NHS Trust

Endoscopy Unit
Worcestershire Royal Hospital
Charles Hastings Way
Worcester
WR5 1DD

Tel: 01905 763333

Date: <Todays Date>
NHS No: <Patient: NHS Number>
Hospital No: <Patient: Hospital Number>

<Patient: Salutation> <Patient: Name Initials> <Patient: Surname>
<Patient: Address>

Dear <Patient: Salutation> <Patient: Surname>

We are writing to inform you that following a review of your notes, a discussion with your referring Consultant, previous endoscopic procedures and the latest National guidance from the British Society of Gastroenterology; your procedure is no longer required.
Our plan will be not to contact you further and your name will be removed from our waiting surveillance program.
However, should you be having any symptoms including:

- Unexplained weight loss,
- Change in bowel habit (not usual for you)
- Vomiting of blood
- Blood loss from the bowel/bottom
- Difficulty in swallowing

Please do not hesitate to visit your General Practitioner for referral to the appropriate teams and we will be more than happy to see you in clinic to discuss your symptoms further.
Yours sincerely

Dictated but not signed

cc. <GP: Surgery>

Supporting Document 1 – Equality Impact Assessment form

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire and Worcestershire Safe and effective health and care services

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Julie Mathew	**Advanced Nurse Practitioner**	**Julie.mathew@nhs.net**
	Karen Macpherson	**JAG/Governance Lead**	**Karen.macpherson5@nhs.net**
Date assessment completed	**29/09/23**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Policy**
What is the aim, purpose and/or intended outcomes of	

this Activity?				
Who will be affected by the development & implementation of this activity?	✓ ✓ ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity ✓ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	The JAG GRS standards for appropriateness have been visited and implemented into the process for vetting.			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Discussion with Gina Gill - Directorate Support manager And implementation by Julie Mathew and Karen Macpherson			
Summary of relevant findings	Updated to reflect the current process.			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		There will be no impact on this group of people
Disability		✓		There will be no impact on this group of people
Gender Reassignment		✓		There will be no impact on this group of people
Marriage & Civil Partnerships		✓		There will be no impact on this group of people
Pregnancy & Maternity		✓		There will be no impact on this group of people
Race including Traveling Communities		✓		There will be no impact on this group of people
Religion & Belief		✓		There will be no impact on this group of people

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		✓		There will be no impact the gender of the patient
Sexual Orientation		✓		There will be no impact on this group of people
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		There will be no impact on this group of people
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		There will be no impact on this group of people

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g. in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	02/10/23
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue?	No
3.	Does the implementation of this document require additional manpower?	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff?	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval