Virtual vetting of bowel screening colonoscopy referrals does not reduce colonoscopy uptake in the Bowel Screening programme

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Background & aim:

Pre-assessment for colonoscopy in the Scottish Bowel Screening Programme (SBSP) is recommended to:

- assess fitness for the procedure
- provide information to allow participants to make an informed choice[1]

Initially assessment was done face-to-face, then moved to telephone.[2]

In symptomatic referral pathways, virtual vetting is well-established:[3,4]

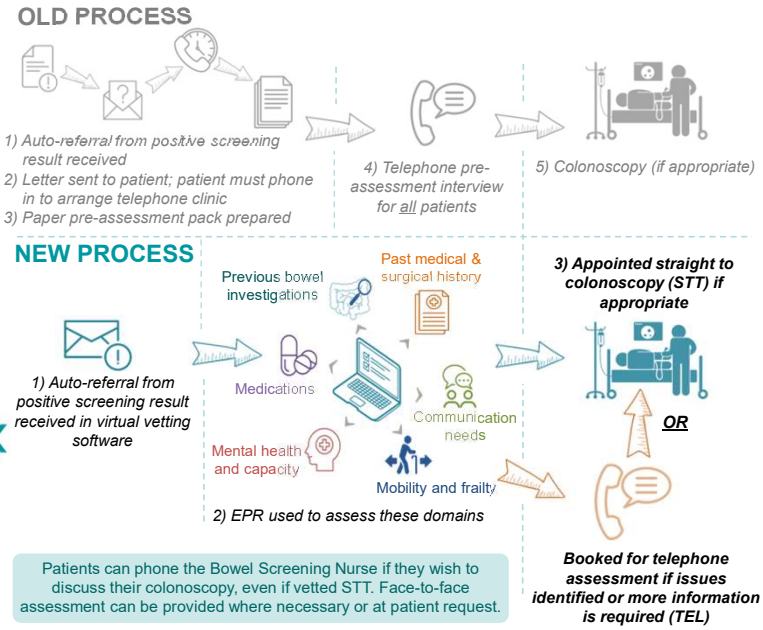
- The referral and electronic patient record (EPR) are used to assess fitness for colonoscopy, allowing patients to go 'straight to test' (STT)
- Information on the preparation, procedure, and risks and benefits is provided by booklets enclosed with the appointment letter.

To date, this approach has not been used in the SBSP due to concerns about lack of information in the auto-generated referral, and because the impact on acceptance and bowel preparation quality was unknown.

We aimed to assess the impact of virtual vetting for bowel screening colonoscopy on both patients and staff.

Process change:

- Post-COVID staffing issues meant change was essential
- A full-time Bowel Screening Nurse was appointed in January 2023
- New IT processes were implemented allowing SBSP auto-referrals to undergo virtual vetting in the same way as symptomatic referrals



Patients can phone the Bowel Screening Nurse if they wish to discuss their colonoscopy, even if vetted STT. Face-to-face assessment can be provided where necessary or at patient request.

Methods:

- Positive screening results were identified from the six months following the vetting process changes (January-July 2023)
- Patients vetted STT were compared to those who had telephone pre-assessment (TEL)

We measured: 1) colonoscopy attendance, 2) patient waiting times, 3) quality of bowel preparation, 4) patient satisfaction, and 5) staff time.

Results:

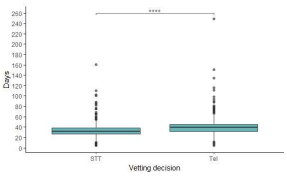
770 patients were included in the study; 401 (52.1%) were referred STT and 369 were assessed by telephone. The STT group were younger than the TEL group (median age 62 v 67 years, p<0.001).

1 COLONOSCOPY UPTAKE AND ATTENDANCE

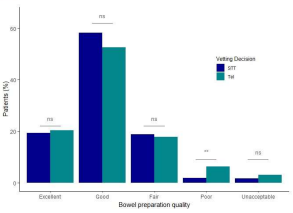
By definition, all patients in the STT group were suitable for colonoscopy. In the TEL group, 315/369 were suitable for colonoscopy. Attendance was higher in the STT group than TEL group (92.8% v 85.7%, p=0.0014).

2 PATIENT WAITING TIMES

- 80% of auto-referrals were vetted the same day and 98% within 3 days (due to weekends and public holidays)
- On average, waiting time from positive screening to colonoscopy was one week shorter for those vetted STT than those who were pre-assessed by telephone (p<0.001)



3 QUALITY OF BOWEL PREPARATION



- Bowel preparation was broadly similar between groups
- Fewer patients had 'poor' or 'unacceptable' preparation in the STT group (3.5% v. 9.3%, p=0.0039)

4 PATIENT SATISFACTION

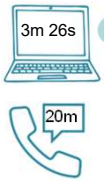
58 patients returned a service evaluation questionnaire:

- Patients were equally highly satisfied regardless of whether they were in the STT or TEL groups (p=0.695)

STT: 4.65/5

TEL: 4.73/5

5 STAFF TIME



Staff time was averaged over a two-week period:

- Mean time for virtual vetting was 3 mins 26 secs per patient
- Mean time for phone assessment was 20 minutes, maximum time was 48 minutes, and up to 8 failed phone calls occurred per day

Conclusions:

- Virtual vetting is now standard practice, allowing over half of patients to go STT without telephone pre-assessment
- STT vetting did ***not*** negatively impact colonoscopy uptake, attendance or bowel preparation quality
- Patients referred STT underwent colonoscopy one week sooner than those assessed by telephone
- Virtual vetting is five times quicker for staff than assessment by telephone
- Patients were equally satisfied with their pre-colonoscopy experience regardless of whether they received a phone call prior to the procedure

Virtual vetting for bowel screening colonoscopy is safe, efficient and acceptable, with no negative impact on uptake

1) Healthcare Improvement Scotland. *Bowel Screening Standards*. Edinburgh 2023. **2)** Rodger J and Steele RJ. Telephone assessment increases uptake of colonoscopy in a FOBT colorectal cancer-screening programme. J Med Screen 2008; 15: 105-107. **3)** Sagar A, Mai DVC, Divya GS, et al. A colorectal straight-to-test cancer pathway with general-practitioner-guided triage improves attainment of the 28-day diagnosis target and increases outpatient clinic capacity. *Colorectal Dis* 2021; 23: 664-671. **4)** Christopher J, Flint TR, Ahmed H, et al. Straight-to-test for the two-week-wait colorectal cancer pathway under the updated NICE guidelines reduces time to cancer diagnosis and treatment. *Ann R Coll Surg Engl* 2019; 101: 333-339.

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