

# Health and Community Services Complaints Act 2004

## Section 54 Report

De-identified version

HCSCC Complaint Ref # 011181

5 September 2014

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### Complaint issues

In August 2012, the Complainant (C) complained to the Health and Community Services Complaints Commissioner (HCSCC) about the excessive waiting times for gastroenterology services at a public hospital between 2010 and 2012. C claims that s/he was forced to have more extensive and invasive surgical treatments as a direct result of the unreasonable delays C had experienced accessing a diagnostic colonoscopy at the hospital.

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### HCSCC investigation into individual complaint

HCSCC began by investigating the individual complaint. C was referred by a specialist to the public hospital as urgently in need of a colonoscopy but then waited on a waiting list for nearly 2 years without receiving one. Although C was assessed as a High Risk Category 2 patient, C was told that the waiting time for a diagnostic colonoscopy was 424 days. This seemed to be an unreasonable delay for any patient awaiting diagnosis and treatment, but of particular concern for patients already assessed as at High Risk.

On 28 May 2013, HCSCC received a letter from the Chief Executive Officer of the public hospital which advised that the demands for gastroenterological services at that hospital were extremely high and increasing; and that the wait time for patients on the High Risk Category 2 list, as of May 2013, was 501 days. This was an increase in the waiting times since C's complaint. In 2010 it had been 424 days which was already considered excessive.

The expected waiting times, triaged according to urgency, were supposed to be:

- Emergency – within 14 days
- Urgent (Category 1) - within 30 days
- Semi Urgent (Category 2) – within 90 days
- Non-urgent (Category 3) – Greater than 90 days

It was apparent that the expected waiting times for gastroenterology services at this particular public hospital were not being met. In fact, at 501 days, the wait times for patients on the semi urgent waiting list appeared to be dangerously delayed and likely putting patients at serious risk of harm.

HCSCC decided to investigate whether the excessive and unreasonable delays in receiving diagnostic treatment was only happening within the gastroenterology department at this particular hospital; or was this situation indicative of a wider problem, happening in all public hospital gastroenterology departments?

In order to determine if gastroenterology services were being provided within the expected standards and that those actions taken to manage the waiting times and lists were reasonable and appropriate, HCSCC determined to investigate these issues. Specifically, the length of time patients were waiting for gastroenterology services, the manner in which waiting lists were maintained and how information about waiting times was being communicated to those patients waiting on waiting lists for gastroenterology procedures at public hospitals.

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## HCSCC systemic investigation

On 5 July 2013, the Health and Community Services Complaints Commissioner (HCSCC) notified the Chief Executive of SA Health that HCSCC had begun an investigation under Part 6 of the Health and Community Services Complaints Act 2004 (the Act) into the systemic issues relating to the waiting times and waiting lists for public gastroenterology services.

HCSCC required SA Health to review the gastroenterology services provided by the particular hospital named in the complaint; as well as review all other gastroenterology departments and provide HCSCC with written advice regarding:

- An overview of the waiting times for those patients on the waiting lists for gastroenterology services across the SA Health Network
- Advice as to whether the waiting times were reasonable and adhering to the standards for expected waiting times, as per the triaged categories, and
- If the waiting times were not reasonable, advice as to what action SA Health would take, or has taken, to address the identified issues of concern.

In September 2013, HCSCC met with SA Health for an explanation of the delay in responding to the HCSCC request for information about gastroenterology services within SA Health.

SA Health provided HCSCC with the following information:

- All the investigative gastroenterology "oscopies" were likely to be included in the National Screening in 2014 and this would change the scope of the review.
- As per the Commissioner's request for information and prior to the expected changes in 2014, SA Health had tried to examine the processes in place to manage gastroenterology services; however there was such huge diversity across the state, information was inconsistent, very difficult to assess and impossible to compare.
- With a view to providing a consistent approach in a very short time, SA Health had already begun a major project aimed at developing a model for a consistent approach to managing and monitoring gastroenterology services throughout SA Health.
- SA Health had been working with the specific hospital to ascertain the true number of patients on the waiting lists there and had undertaken measures to expedite the services needed to pick up patients, who had been waiting excessive times, and process them through to treatment.

On 5 November 2013, HCSCC received a letter from SA Health providing their overview of the waiting times for gastroenterology services across SA Health and the actions that SA Health intended to take to address the identified concerns. It was noted that at present, public gastroenterology outpatient services including colonoscopies were managed by each of the Local Health Networks and were not part of any statewide waiting list management procedure or performance monitoring arrangement.

In the main, apart from the particular hospital named in the individual complaint, it appeared that most gastroenterology departments had less than 6 months waiting time for new patients, which were often shorter (14 – 60 days) for those patients categorised as urgent. Although the exact patient demand could not be clarified, it was acknowledged that immediate action was needed to remedy the waiting times for those patients facing excessive delays and that this work had already begun.

In parallel with the action taken to address the shortfalls in service at the hospital named in the complaint, SA Health determined to clarify the current service demand and improve the management of gastroenterology services across all SA Health sites, with an initial focus on colonoscopies. This was to include:

- A full review of colonoscopy services
- Prioritised development of an SA Health *Medical Waiting List Management Policy and Guidelines for Colonoscopy Categorisation and Surveillance Timing*.
- Extension of the Booking List Information System (BLIS) to include gastroenterology procedures

On 4 December 2013, HCSCC wrote to SA Health again; acknowledging the actions already begun to address the systemic concerns identified in the management of wait times in gastroenterology departments and requesting an update on the progress of the planned initiatives needed to improve gastroenterology services in the public interest.

On 6 January 2014, SA Health advised HCSCC that a Statewide Gastroenterology Scopes Working Group had been established to progress the improvements to colonoscopy services throughout SA Health. The group would develop and implement:

- Colonoscopy Urgency Categorisation, and
- Surveillance Timing Guideline, and
- A procedure for the Booking List Information System to enable, for the first time, statewide reporting on waiting lists.

SA Health advised that once these reforms had been completed for colonoscopies; and to facilitate timely and appropriate treatment in other diagnostic and surveillance procedures; the reforms would be extended to other gastroenterology services. In addition, SA Health proposed to include a Colonoscopy Service Improvement Initiative in the new *Elective Procedures Strategy 2014-15 – 2017-18* as a public commitment to colonoscopy service reforms; and provide significant funding for additional colonoscopy procedures to be undertaken.

On 5 June 2014, HCSCC required SA Health to provide a further update on the implementation of the gastroenterology service reforms.

On 16 Jul 2014, SA Health advised that the Colonoscopy Urgency Categorisation and Surveillance Timing Policy Guideline was finalised and had been endorsed by the Portfolio Executive on 17 June 2014. (A copy of the Colonoscopy Urgency Categorisation and Surveillance Timing Policy Guideline is included as an attachment to this report.)

SA Health also advised that there are now twelve separate indicator procedure codes that will allow for colonoscopies procedures and other common gastroenterology procedures to be placed on waiting lists by using the Booking List Information Service (BLIS). These procedure codes will allow for more accurate patient tracking and greater collection of data with a view to obtaining monthly reports from all SA Health sites.

A Service Improvement Project Officer had been appointed in three Local Health Networks, Southern, Central and Northern with additional resources provided to Country Health to assist with implementing the reforms.

Finally, colonoscopies had been targeted under the *Electives Procedure Strategy 2014-15 – 2017-18* which meant that a significant investment of time and resources would be directed towards the better management and more timely delivery of public colonoscopy services in South Australia; with this process eventually broadened to achieve the same improvements in other gastroenterology services as well.



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## Conclusion

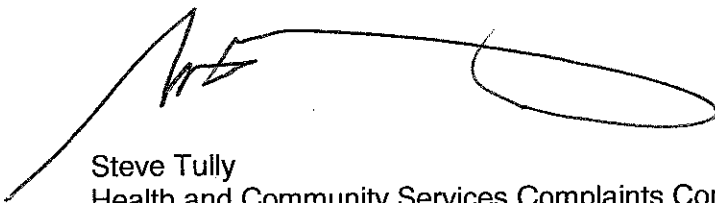
Although the reforms have not been in place long enough to produce the data necessary to provide HCSCC with an overview of the waiting times per triaged category for gastroenterology services throughout SA Health; it is evident that the Colonoscopy Urgency Categorisation and Surveillance Timing Policy Guideline has been developed and implemented.

SA Health has applied concerted effort to generally improving the gastroenterology services across the state and is better managing the waiting lists, reducing patient wait times and the chance that patients will be overlooked on waiting lists.

Given there have been measures put in place to reduce the waiting times for gastroenterology services at the particular hospital named in the complaint (which appeared to be the only site where the waiting times were seriously out of control), it is expected that when the data is available it will show the positive affects of the increased attention on better management of the waiting lists according to the new Colonoscopy Urgency Categorisation and Surveillance Timing Policy Guideline. Also increased time and resources, specifically dedicated to improving gastroenterology services in South Australia, will improve wait times and patient outcomes.

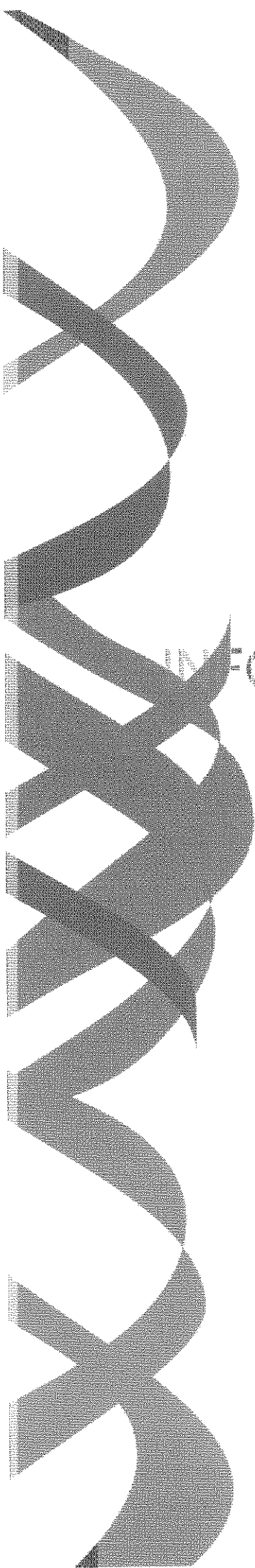
Is it possible to say that no patient will ever have to spend an excessive and unreasonable amount of time on a waiting list, waiting to access public gastroenterology services in South Australia? No, of course we can't; but we can say that the work done by SA Health as a result of this investigation into the systemic concerns identified by C - about the delays C experienced accessing public gastroenterology services at the public hospital - has already reduced the chance that others will experience adverse affects from excessive waiting times for public gastroenterology services.

The introduction of better statewide management and monitoring of gastroenterological services will help to ensure that excessive waiting times for patients will be noticed, and addressed, and that this is much more likely to happen before it poses a major health risk.



Steve Tully  
Health and Community Services Complaints Commissioner

Date: 20 January 2015



# Colonoscopy Urgency Categorisation and Surveillance Timing Policy Guideline

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Government  
of South Australia

SA Health

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## Endorsements

Date	Endorsed by
2/5/14	SA Health Gastroenterology Scopes Working Group

## Approvals

Date	Approved by
17/6/14	Portfolio Executive

# Draft Colonoscopy Urgency Categorisation and Surveillance Timing Policy Guideline

## 1. Objective

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The *Colonoscopy Urgency Categorisation and Surveillance Timing Policy Guideline* provides advice to SA Health services and clinicians on urgency categorisation and appropriate surveillance intervals for patients requiring a planned colonoscopy. Through implementing consistent urgency categorisation practices across all SA Health services the Policy Guideline aims to contribute to both the timely treatment of individuals, and equitable prioritisation and access to procedures for all patients.

The Policy Guideline addresses the varying needs and service provision arrangements for adults and children requiring a planned colonoscopy. Section 4 of the Policy Guideline relates to adult patients and sets out detailed usual urgency categories and surveillance timing intervals based on National Health and Medical Research Council endorsed guidelines. Section 5 relates to the provision of colonoscopies to children and reflects the established clinical practices of the specialist state-wide paediatric service run by the Gastroenterology Unit of the Women's and Children's Hospital. Whilst there is variation in the indications for colonoscopy for adults and children, the appropriate clinical timeframe for a colonoscopy procedure is denoted by the urgency category assigned by the patients treating public hospital clinician. The urgency category timeframes are consistent for all patients, regardless of age, and are as follows:

- Category 1** Colonoscopy should be provided within 30 days  
**Category 2** Colonoscopy should be provided within 90 days  
**Category 3** Colonoscopy is required within 365 days  
**Category 4** **Deferred patients**, which includes surveillance patients who require a surveillance colonoscopy at a specified date in the future, and patients who require a colonoscopy but are not 'ready for care'

Urgency categories are assigned by SA Health clinicians to indicate the clinically appropriate time within which a patient should receive a required procedure, taking into consideration the patient's symptoms, medical history and risk factors.

Whilst it is anticipated that the usual urgency categories and surveillance timing set out for adult patients will be suitable in most circumstances, it is acknowledged that the criteria are not exhaustive and there will be exceptional cases where the appropriate urgency categorisation or surveillance interval will vary and a different approach will be clinically appropriate. In addition, as outlined in section 5 of the Policy Guideline, the provision of colonoscopy to children is highly individualised and appropriate urgency categorisation and treatment planning will be determined through medical review, with patients monitored closely on an ongoing basis. It remains the responsibility of treating SA Health clinicians to determine the most appropriate clinical treatment for individual patients.

New evidence regarding best practice use of colonoscopy is continually evolving, and as such, this Policy Guideline will be reviewed and updated every 2 years to ensure it remains current. The Policy Guideline may also be reviewed at other times if new information becomes available.

## 2. Scope

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This Policy Guideline applies to all SA Health gastroenterology services and is to be utilised by all clinical, administrative and service management staff to guide appropriate and consistent waiting list management and patient prioritisation practices for the provision of planned colonoscopy procedures. Patients requiring an emergency colonoscopy (to be undertaken within 24 hours) are not assigned an urgency category or added to procedural waiting lists.

## 3. Principles

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1. The provision of public colonoscopy services will be based on clinical need and equity of access.
2. Timely service delivery is a priority for all SA Health services and patients requiring a colonoscopy should receive it within the clinically recommended time.
3. SA Health services will aim for consistency of practice and will actively monitor and manage waiting lists to ensure effective demand management and appropriate prioritisation practices.
4. The clinical treatment of patients remains the responsibility of their treating clinicians.

## 4. Colonoscopy for adult patients

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Section 4 of the policy guideline relates to the provision of colonoscopy to adults through the public health system. These procedures are usually provided by the gastroenterology services of adult (non-paediatric) public hospitals, with some hospitals also offering specialist surveillance programs for patients with specific conditions or risk factors.

### 4.1. Usual urgency categorisation

'Usual urgency categories' have been defined in order to promote equity of access to public colonoscopy services and to encourage consistency in the prioritisation and treatment of patients with similar symptoms or risk factors. The urgency category for a patient is to be allocated by an experienced public hospital clinician based on the patient's clinical need.

The measurement of patient waiting time for a colonoscopy commences from the time a public hospital clinician determines that a procedure is required and adds the patient to the procedural waiting list, and concludes at the time that the patient receives the required procedure. The tool for measuring colonoscopy procedure waiting times is the Booking List Information System (BLIS). For BLIS purposes, the patient's treating public hospital clinician is referred to as the *authorised medical practitioner or delegate*.

#### 4.1.1 Diagnostic colonoscopy for symptoms

It is recommended that all adult patients with suspicious large bowel symptoms or rectal bleeding should be investigated, especially if other risk factors (such as older age or family history) are present. Alarm symptoms have been identified to include:

- weight loss
- severe pain
- anaemia
- palpable mass.

Table 1 outlines the recommended usual urgency categories for adult patients requiring a colonoscopy through the public health system.

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**Table 1: Usual urgency categories for adults requiring diagnostic or surveillance colonoscopy**

Recommended Urgency Category*	Symptoms / Surveillance
1 (within 30 days)	<ul style="list-style-type: none"> <li>• Faecal Rapid Test (FRT) positive result, National Bowel Cancer Screening Program</li> <li>• Clinically significant rectal bleeding</li> <li>• Clinically significant iron deficiency anaemia</li> <li>• Change in bowel habit with alarm symptoms</li> <li>• Active or suspected inflammatory bowel disease (IBD) or diarrhoea where endoscopy is indicated to progress management</li> <li>• Abnormal imaging where cancer is suspected</li> </ul>
2 (within 90 days)	<ul style="list-style-type: none"> <li>• Change in bowel habit without alarm symptoms</li> <li>• Persistent/chronic diarrhoea</li> <li>• Port diverticulitis</li> <li>• <b>Staged Surveillance Patient</b> for whom a surveillance procedure is due within the next 90 days. This includes:               <ul style="list-style-type: none"> <li>○ Patients requiring initial surveillance following removal of certain adenomas or in certain circumstances post curative resection for obstructive colorectal cancer (CRC).</li> <li>○ Patients requiring surveillance related to family history or previous adenoma, curative resection for CRC or dysplasia in inflammatory bowel disease.</li> </ul> </li> </ul> <p>Refer to section 4.1.1 for details of the urgency categorisation process for Staged Surveillance Patients.</p>
3 (within 12 months)	<ul style="list-style-type: none"> <li>• Colonoscopy required within 365 days.</li> </ul>
4 (not ready for care)	<ul style="list-style-type: none"> <li>• <b>Staged Surveillance Patient</b> for whom surveillance is planned at a set interval at some time in the future. Refer to section 4.1.2 for details of the urgency categorisation process, and section 4.2 for advice on determining appropriate surveillance timing.</li> <li>• <b>Deferred Patient</b> that requires a colonoscopy within the next 12 months but for whom the procedure has been deferred, either for clinical reasons (patient is temporarily unfit for procedure) or personal reasons.</li> </ul> <p><b>NOTE: A patient cannot be assigned as 'ready for care' on the BLIS more than 12 months in advance.</b></p>

\* Generally, malignancy will be considered to require treatment within 30 days.

*Source: Information drawn from Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer 2005. Clinical Practice Guidelines for Surveillance Colonoscopy 2011. Waiting Time and Elective Surgery Policy, NSW Health. Assessment and Access Criteria for Public Colonoscopy Services, WA Health*

#### **4.1.2 Urgency categorisation –Surveillance Patients**

Through the BLIS, patients that are 'ready for care' for a procedure required within the next 12 months are assigned as Category 1, 2 or 3. The assignment of one of these three Categories indicates that the patient is *ready and available to be booked to undergo the procedure at the next available opportunity*.

For surveillance patients who require a colonoscopy at a set interval at some time in the future (for example 6 months, 12 months, 3 years or 5 years), a specific urgency categorisation process is required to ensure that the patient is booked when the procedure is due and is not specified as 'ready for care' earlier than appropriate. A summary of the process for urgency categorisation of surveillance patients is as follows:

- **Public hospital treating clinician (authorised medical practitioner or delegate)** determines surveillance is required at a set interval at some time in the future, and

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completes a booking form specifying the *date the procedure is due*, relevant *BLIS surveillance Indicator Procedure Code*, and assigning the patient as *Category 2*.

- **Patient is added to the BLIS** as Category 2, and then manually changed to Category 4 surveillance patient where they remain as 'not ready for care' until one month before the procedure due date. At this time, the patient reverts to Category 2 'ready for care'.

## 4.2 Surveillance timing

The following sections of the guideline set out recommended timing for surveillance colonoscopies for adults, where there is a family history of colorectal cancer (CRC), post adenoma, post curative resection for CRC, and for surveillance and management of dysplasia in inflammatory bowel disease.

### 4.2.1 Colonoscopy related to family history

Table 2: Risk ranking related to family history and surveillance timing

Patient Risk Level	Risk Factors	Surveillance Timing
<b>Slightly above average risk</b>	<ul style="list-style-type: none"> <li>• 1 first degree or second degree relative diagnosed with CRC at age 55 or older</li> <li>• 2 relatives diagnosed with CRC aged 55 or older but on different sides of the family</li> </ul>	Screening should be as for the average-risk population. FRT should be conducted every 2 years from 50 years of age.
<b>Moderately increased risk</b>	<ul style="list-style-type: none"> <li>• 1 first degree relative diagnosed with CRC before age 55 (without potentially high risk features outlined below)</li> <li>• 2 first degree, <u>or</u> 1 first degree and 1 second degree relative/s on the same side of the family diagnosed with CRC at any age (without potentially high risk features outlined below)</li> </ul>	Colonoscopy to be done every 5 years starting at age 50, or at an age 10 years younger than first diagnosis of CRC in the family, whichever comes first
<b>High risk</b>	<ul style="list-style-type: none"> <li>• 3 or more first degree relatives <u>or</u> a combination of first and second degree relatives on the same side of the family diagnosed with CRC at any age</li> <li>• 2 or more first or second degree relatives on the same side of the family diagnosed with CRC, plus any of the following high risk features: <ul style="list-style-type: none"> <li>- Multiple CRCs in a family member</li> <li>- CRC before the age of 50</li> <li>- Family member who has/had a Hereditary non-polyposis colorectal cancer (HNPCC) or a related cancer (endometrial, ovarian, stomach, small bowel, renal pelvis or ureter, biliary tract, brain cancer)</li> </ul> </li> <li>• At least 1 first degree or second degree relative with a large number of adenomas throughout the large bowel (suspected FAP)</li> <li>• Member of family in which a gene mutation that confers a high risk of CRC has been identified</li> </ul>	<p>The high risk adult population is small in size. Adults assessed as being high risk require close management and development of a treatment plan specific to their clinical needs. Patients should be referred for medical review prior to colonoscopy.</p> <p>Endorsed options for surveillance timing include: HNPCC: Yearly or 2 yearly from age 25, or 5 years younger than first diagnosis of CRC in the family, whichever comes first</p> <p>Annual screening should be offered to individuals carrying a germline mutation and for clinically affected individuals in Amsterdam families where mutation status is unknown</p>

**Source:** *Familial Aspects of Bowel Cancer: A Guide for Health Professionals*, The Royal Australian College of General Practitioners July 2008

## 4.2.2 Post Adenoma

**Table 3: Surveillance timing for adenoma follow-up**

Finding at colonoscopy	Initial surveillance interval	Subsequent interval
1 or 2 small tubular adenomas (< 10 mm)	5 years	If surveillance colonoscopy is normal, patient considered at average risk for metachronous disease. FRT every one to two years.
High risk adenomas – <ul style="list-style-type: none"> <li>• 3 or more lesions</li> <li>• ≥ 10 mm</li> <li>• With tubulovillous or villous histology</li> <li>• High grade dysplasia</li> </ul>	3 years	<b>A</b> (Refer notes below)
Large and sessile adenomas removed piecemeal and/or by endoscopic mucosal resection (EMR)	3 to 6 months, and again at 12 months	If removal is complete, subsequent surveillance should then be based on histological findings, size and number of adenomas as set out above.
5 or more adenomas	12 months	<b>A</b> <b>B</b>
5 or more adenomas, where polyposis syndrome accounts for findings	Within 12 months	<b>A</b> <b>B</b>
10 or more adenomas	Within 12 months	<b>AB</b>
Family history – should be considered separately when planning colonoscopy surveillance	Intervals should be predominantly determined by the adenoma characteristics, unless a syndromic risk mandates more frequent surveillance.	<b>B</b>

**A:** if advanced adenomas are found during subsequent surveillance, maintaining a three yearly surveillance schedule is prudent, but the choice should be individualised. The interval can be lengthened if advanced adenomas are not found.

**B:** consider referring for genetic testing

**Source:** *Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease, Chapter 2 Management of epithelial polyps: Colonoscopic surveillance after polypectomy, December 2011*

### 4.2.3 Post curative resection for colorectal cancer

It is recommended that a perioperative colonoscopy should be attempted in all adult patients with a newly diagnosed CRC, followed by initial and subsequent surveillance.

**Table 4: Initial and subsequent surveillance timing following CRC diagnosis**

Clinical scenario	Initial surveillance timing	Subsequent timing
Obstructive CRC, where a complete peri-operative colonoscopy was not performed, and there is residual colon proximal to the obstructing cancer	3 to 6 months	If surveillance colonoscopy reveals advanced adenoma, then the interval before the next colonoscopy should be 3 years  If surveillance colonoscopy at 3 to 6 months is normal or identifies no advanced adenomas, the interval before the next colonoscopy should be 5 years
Sporadic CRC	12 months, unless a complete post-operative colonoscopy has been performed sooner	If surveillance colonoscopy reveals advanced adenoma, then the interval before the next colonoscopy should be 3 years  If surveillance colonoscopy at 12 months is normal or identifies no advanced adenomas, the interval before the next colonoscopy should be 5 years

*Source: Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease, Chapter 3 Follow-up after curative resection for colorectal cancer, Cancer Council Australia, December 2011*

Table 5 outlines a number of practice points relevant to adults at very high risk for metachronous neoplasia following a resection for CRC.

**Table 5: Practice points on surveillance timing for high risk metachronous neoplasia**

Clinical scenario	Surveillance timing
Hereditary non-polyposis colorectal cancer (HNPCC)	Adult patients should continue to have an annual colonoscopy post-operatively because of the apparent rapid progression of neoplasia from adenoma to carcinoma
Residual colonic mucosa in patients with cancer in Familial Adenomatous Polyposis (FAP)	Surveillance should follow the guidelines for high risk familial history outlined in section 3.2.1
Adult patients including those: <ul style="list-style-type: none"> <li>(i) whose initial diagnosis was made younger than 40 years of age</li> <li>(ii) with probable or possible HNPCC (i.e. patients whose tumours are MSI-high and less than 50 years old at time of initial cancer diagnosis but not proved by genetic testing to have HNPCC)</li> <li>(iii) with hyperplastic polyposis and BRAF mutation and</li> <li>(iv) with multiple synchronous cancers or advanced adenomas at initial diagnosis</li> </ul>	Adult patients should be considered following surgery to continue with more frequent surveillance than would otherwise be recommended (e.g. initial post-operative colonoscopy at one year and then annually, second-yearly or third-yearly).

*Source: Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease, Chapter 3 Follow-up after curative resection for colorectal cancer, December 2011*

#### 4.2.4 Colonoscopic surveillance and management of dysplasia in inflammatory bowel disease

Colonoscopic surveillance is recommended in high risk adult patients with ulcerative colitis (UC) to reduce cancer-related mortality, as set out in Table 6. Associated practice points are outlined in Table 7.

**Table 6: Screening for high risk adult patients with inflammatory bowel disease (IBD)**

Finding at colonoscopy	Surveillance timing
Ulcerative colitis extending beyond the sigmoid colon	No later than 8 years after onset of symptoms, or earlier if a strong personal family history of CRC; or At the time of diagnosis of Primary Sclerosing Cholangitis (if diagnosed)
Crohn's disease that involves more than one-third of colon	No later than 8 years after onset of symptoms, or earlier if a strong personal family history of CRC; or At the time of diagnosis of Primary Sclerosing Cholangitis (if diagnosed)

**Source:** Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease, Chapter 4 Colonoscopic surveillance and management of dysplasia in inflammatory bowel disease (IBD), December 2011

**Table 7: Surveillance for inflammatory bowel disease (IBD) in adults**

Finding at colonoscopy	Surveillance timing
Ulcerative colitis extending proximal to the sigmoid colon or adult patients with Crohn's colitis affecting more than one third of the colon and with one or more of the following risk factors: <ul style="list-style-type: none"> <li>• Active disease</li> <li>• Primary sclerosing cholangitis</li> <li>• Family history of CRC in first degree relative &lt; 50 years old</li> <li>• Colonic stricture, patients with multiple inflammatory polyps or shortened colon</li> <li>• Previous dysplasia</li> </ul>	Annually
<ul style="list-style-type: none"> <li>• Inactive ulcerative colitis extending proximal to the sigmoid colon without any of the risk factors listed in the row above</li> <li>• Crohn's colitis affecting more than one third of the colon without any of the risk factors listed in the row above</li> <li>• IBD with a family history of CRC in a first degree relative &gt; 50 years old</li> </ul>	3 yearly
Two previous colonoscopies that were macroscopically and histologically normal	5 yearly

**Source:** Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease, Chapter 4 Colonoscopic surveillance and management of dysplasia in inflammatory bowel disease (IBD), December 2011

## 5. Colonoscopy for children

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Section 5 of the Policy Guideline relates to the provision of colonoscopies to children through the public health system. These procedures are almost exclusively provided by the Gastroenterology Unit at the Women's and Children's Hospital which provides a state-wide specialist paediatric service for children and adolescents. Colonoscopies for children and adolescents account for a small proportion of the total procedures undertaken through the total public health system, however there is an increasing demand for the procedure, highlighting the need to ensure the appropriate urgency categorisation based on clinical need to promote equity of access and the appropriate prioritisation of patients awaiting a procedure.

### 5.1 Urgency categorisation of children

The use of colonoscopy for both diagnostic and surveillance purposes is highly individualised and almost all procedures are undertaken with a general anaesthetic. For these reasons, detailed 'usual' urgency categories and surveillance timing intervals have not been specified. The determination of appropriate timing and indications for colonoscopy to children will be individually determined for each patient by the treating paediatric gastroenterologist. The information outlined below provides general guiding information only to assist clinicians in determining the appropriate treatment plan and urgency categorisation for children.

The urgency category for children requiring a colonoscopy is to be allocated by an experienced public hospital clinician (authorised medical practitioner or delegate) based on the patient's clinical need.

Table 8 sets out the urgency categories for children requiring a diagnostic or surveillance colonoscopy through the public health system.

#### 5.1.1 Diagnostic colonoscopy for symptoms

Diagnostic colonoscopy is indicated for children when investigating for: suspected inflammatory bowel disease; iron deficiency anaemia with GI blood loss; and overt bleeding from the bowel thought to be of colonic origin.

Where malignancy is suspected, this will generally require investigation and treatment within 30 days.

#### 5.1.2 Colonoscopy for surveillance

Colonoscopy is used as a surveillance tool for children with long term inflammatory bowel disease and for children over the age of 10 years with familial adenomatous polyposis to monitor for dysplasia.

The appropriate surveillance timing for each child should be determined on an individual basis taking into consideration the child's clinical condition and being mindful of the need to administer a general anaesthetic to undertake the procedure. The most common surveillance interval for children requiring a colonoscopy is 12 months, however it may be more appropriate to conduct surveillance at two yearly intervals.

**Table 8: Urgency categorisation for children requiring diagnostic or surveillance colonoscopy**

<b>Category 1:</b> Colonoscopy required within 30 days
<p><b>Category 2:</b> Colonoscopy required within 90 days, including <b>Staged Surveillance Patients</b> for whom a planned procedure is due within 90 days.</p> <p>Refer to section 5.1.3 for details of the urgency categorisation process for Staged Surveillance Patients.</p>
<b>Category 3:</b> Colonoscopy required within 365 days
<p><b>Category 4:</b> <b>Staged Surveillance Patient</b> for whom surveillance is planned at a set interval at some time in the future. Refer to section 5.1.3 for details of the urgency categorisation process, and section 5.1.2 for information on surveillance colonoscopies for children.</p> <p><b>Deferred Patient</b> that requires a colonoscopy within the next 12 months but for whom the procedure has been deferred, either for clinical reasons (patient is temporarily unfit for procedure) or personal reasons.</p> <p><b>NOTE: A patient cannot be assigned as 'ready for care' on the BLIS more than 12 months in advance.</b></p>

**5.1.3 Urgency categorisation – Staged Surveillance Patients greater than 12 months**

Through the BLIS, patients that are 'ready for care' for a procedure required within the next 12 months are assigned as Category 1, 2 or 3. The assignment of one of these three Categories indicates that the patient is *ready and available to be booked to undergo the procedure at the next available opportunity*.

For surveillance patients who require a colonoscopy at a set interval at some time in the future (for example 6 months, 12 months, 3 years or 5 years), a specific urgency categorisation process is required to ensure that the patient is booked when the procedure is due and is not specified as 'ready for care' earlier than appropriate. A summary of the process for urgency categorisation of surveillance patients is as follows:

- **Public hospital treating clinician (authorised medical practitioner or delegate)** determines surveillance is required at a set interval at some time in the future, and completes a booking form specifying the *date the procedure is due*, relevant *BLIS surveillance Indicator Procedure Code*, and assigning the patient as *Category 2*.
- **Patient is added to the BLIS** as Category 2, and then manually changed to Category 4 surveillance patient where they remain as 'not ready for care' until one month before the procedure due date. At this time, the patient reverts to Category 2 'ready for care'.

## 6. Roles and Responsibilities

**Chief Executive Officers, Local Health Networks** are responsible for ensuring that all staff involved in the provision of colonoscopy services are informed about the guideline.

**Health Service Divisional Directors** are responsible for promoting service provision in accordance with the guideline.

**Clinicians** are responsible for ensuring they are familiar with the guideline and the specified usual urgency categories and surveillance timing.

**Administrative staff** that add patients to the Booking List Information System (BLIS) are responsible for ensuring that diagnostic and surveillance patients are added to the correct clinical urgency category assigned by the treating clinician, and that surveillance patients greater than 12 months are managed in line with the provisions of this guideline.

## 7. Reporting

Not applicable.

## 8. EPAS Considerations

Not applicable.

## 9. Associated Policy Directives / Policy Guidelines











- Elective Surgery Policy Framework and Associated Procedural Guidelines.
- Booking List Information System (BLIS) Guidelines.

## 10. References, Resources and Related Documents

- NHMRC *Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer 2005*
- NHMRC *Clinical Practice Guidelines for Surveillance Colonoscopy – in adenoma follow-up; following curative resection of colorectal cancer; and for cancer surveillance in inflammatory bowel disease 2011*
- Cancer Council of Australia's *Familial Aspects of Bowel Cancer: A Guide for Health Professionals (updated July 2008)*
- New South Wales Government Health Information Bulletin *Advice for Referring and Treating Doctors*
- Western Australian Department of Health *Operational Directive Assessment and Access Criteria for Public Colonoscopy Services*

## 11. National Safety & Quality Health Service Standards

This Guideline contributes to National Standard 1: Governance for Safety and Quality in Health Care.

									
National Standard 1	National Standard 2	National Standard 3	National Standard 4	National Standard 5	National Standard 6	National Standard 7	National Standard 8	National Standard 9	National Standard 10
Governance for Safety and Quality in Health Care	Partnering with Consumers	Preventing & Controlling Healthcare associated Infections	Medication Safety	Patient Identification & Procedure Matching	Clinical Handover	Blood and Blood Products	Preventing & Managing Pressure Injuries	Recognising & Responding to Clinical Deterioration	Preventing Falls & Harm from Falls
<input checked="" type="checkbox"/>									

## 12. Other

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Not applicable.

## 13. Evaluation

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The policy guideline will be evaluated and reviewed every two years to ensure it remains reflective of best practice and nationally endorsed clinical guideline. Review and amendment may occur more frequently if new information becomes available.

## 14. Definitions

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**Authorised medical practitioner** is the public hospital medical practitioner with overall responsibility/accountability for the care of a patient on a public hospital waiting list. Within Local Health Networks the authorised medical practitioner may hold the role of Divisional Director, Divisional Chief, Clinical Director or Head of Unit or is the medical practitioner who will perform the procedure.

The medical practitioner must be registered by the Medical Board of South Australia and be employed by a Local Health Network. These practitioners include senior consultant, consultant, senior visiting medical specialist/officer, visiting medical specialist/officer, and clinical academic.

An authorised medical practitioner may delegate the task of clinical urgency categorisation to a nominated clinician where clearly defined categorisation protocols have been documented by Local Health Network.

**Category 1 Patient** is a patient for whom it has been determined, by their treating public hospital clinician, that a colonoscopy is required urgently and within the next 30 days. For adult patients, they fit the 'symptoms/surveillance' criteria outlined in the Category 1 section of *Table 1: Usual urgency categories for diagnostic and surveillance colonoscopy* within this guideline.

**Category 2 Patient** is a patient for whom it has been determined, by their treating public hospital clinician, that a colonoscopy is required semi-urgently and within the next 90 days. For adult patients, they fit the 'symptoms/surveillance' criteria outlined in the Category 2 section of *Table 1: Usual urgency categories for diagnostic and surveillance colonoscopy* within this guideline.

**Category 3 Patient** is a patient for whom it has been determined, by their treating public hospital clinician, that a colonoscopy is required non-urgently and within the next 365 days.

**Category 4 (not ready for care) Patient** is a patient who requires a colonoscopy but who is deferred.

**Deferred Patient** includes a **surveillance patient** who requires a colonoscopy at a specified date in the future, or a patient who requires a colonoscopy within the next 365 days but for whom the procedure has been deferred either for personal reasons (for example the patient is going on an overseas holiday) or for clinical reasons (for example the patient is temporarily unfit for the procedure).

**Diagnostic colonoscopy** is a colonoscopy undertaken for the purpose of diagnosing a patient's symptoms.

**Ready for care patient** is a patient for whom it has been determined, by their treating clinician, that a colonoscopy is required at some time within the next 12 month period, and the patient is clinically ready and able to undergo the procedure. These patients fall into one of the following categories: Category 1, Category 2 or Category 3.

**Surveillance patient** is a patient for whom it has been determine, by their treating public hospital clinician, that a planned surveillance colonoscopy is required at some time in the future.

**Surveillance colonoscopy** is a colonoscopy undertaken on a patient without active/current symptoms who has had a previous colonoscopy and requires surveillance related either to abnormal past results or some other risk factor (for example a family history of CRC).

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