NBSP Primary Care FAQs

How does the National Bowel Screening Programme (NBSP) invitation process work?
Participants in a DHB are screened every two years. Half the population are invited in the first year and half in the second year in an ongoing cycle. This is determined by birth dates (odds/ evens). Participants are sent a pre-invitation letter and information about the NBSP, followed by an invitation letter and Faecal Immunochemical Test (FIT) kit, which they are asked to complete at home and send by Freepost to the laboratory for testing.

When the invitations are sent out to participants, are the General Practice (GP) team notified?
GP teams are not notified by the NBSP when invitations are sent out. However, if a person has a positive result, their GP team is notified. The GP team then contacts the participant and sends a referral to the DHB endoscopy unit for a colonoscopy. Participants receive a letter advising them of the results of their test if it is negative. The GP team is also advised of a negative result via the usual laboratory result process, if the participant has consented to their GP team receiving these results.

What percentage of participants have a positive result?
The positivity rate in the Bowel Screening Pilot was around seven percent. In the NBSP we anticipate a positivity rate of five percent, however this will vary from DHB to DHB depending upon demographics.

If a person is invited and does not respond, what happens?
A reminder letter is sent, but for priority groups (Māori, Pacific and Quintile 5) the National Coordination Centre (NCC) attempts to contact the participant by phone, including during after-hours. If people still can't be contacted, their details are passed on to DHBs to follow up. The role of GP teams is to encourage and promote participation.

What advice should General Practice teams give to people who are over 50 but under 60 who would like to participate?
People aged 50-59 are not eligible for the NBSP but they should be assessed for the presence of factors associated with an increased risk of developing bowel cancer. These include a family history of bowel cancer or a personal history of inflammatory bowel disease (IBD) and previous bowel polyps or cancer. More information is available here: National Referral Criteria for Direct Access Outpatient Colonoscopy or CT Colonography (Word, 103 KB)

Note: If the GP team is aware that the person is experiencing symptoms that are consistent with bowel cancer then they should be referred to their DHB for specialist assessment or for colonoscopy using the direct access referral criteria for colonoscopy.
https://www.health.govt.nz/.../referral-criteria-direct-access-outpatient-colonoscopy-ct

Which referral form should primary care teams use?
Each DHB will have their own system and form for referral. Referral of participants for a colonoscopy (following a positive result) should be to the DHB of residence (domicile). Some DHBs use a manual system, others will use their existing e-referral processes whilst at the same time ensuring that the screening colonoscopies are distinct from the normal referrals for colonoscopies. Cross DHB referrals will use existing systems for this process.

What is an 'information referral'?
Information referrals are sent the same way that an NBSP screening colonoscopy referral is sent to the DHB. It is to let the DHB know that a participant has chosen to have a follow on colonoscopy in the private sector, or to advise of other reasons why a participant should not proceed to colonoscopy.

Who is able to make referrals to DHBs for participants with a positive result?
General Practitioners, Nurse Practitioners or Registered Nurses are able to make these referrals.

How do GP teams receive the results of the colonoscopy?
The endoscopy report is given to the participant and also sent to the GP via the normal channels. A letter is sent to the GP team advising them of the histology results and the outcome, i.e. return to the NBSP screening or exit to surveillance.

What if the participant is unable to undergo a colonoscopy?
All participants referred for a colonoscopy will undergo a pre-assessment, usually by phone, by the endoscopy nurse at their DHB endoscopy unit. On occasions, for a variety of reasons, a participant may not be able to undergo a colonoscopy. In this situation they may be able to proceed instead to a CTC which is a less invasive procedure. This will be decided by the DHB endoscopy unit staff.

Are coeliac patients at higher risk of bowel cancer?
Specialists advise that the risk of bowel cancer in coeliac patients is not significantly higher than the normal population.

If a participant with a positive result wishes to be referred to a private provider for a colonoscopy how will this work?
The GP or health practitioner will need to advise the DHB endoscopy unit that the participant chose to have a private colonoscopy by sending an INFORMATION REFERRAL. It is important to ensure this is sent, otherwise the participant will be contacted by the DHB after 10 days as part of the NBSP fail-safe follow-up process. It also ensures the GP is paid for the information referral.

What are the likelihood of complications and possible adverse events of undergoing a colonoscopy?
Colonoscopy is considered a safe procedure, with few risks. However, as with most medical procedures, problems can sometimes arise. There is a small risk the colonoscopy procedure itself, or removal of polyps, will cause serious bleeding or damage to the bowel that may need further treatment. Adverse events are documented and followed up.

What is the sedation given to a person undergoing a colonoscopy? Are patients able to drive after the procedure?
The sedation used (commonly fentanyl and midazolam, sometimes propofol or nitrous oxide) will determine whether a person can drive after a colonoscopy. The sedation used varies from DHB to DHB. The participant will be advised at the pre-assessment appointment as to whether it is safe for them to drive after the procedure.

What is the policy around Warfarin or other anticoagulants being used prior to undergoing a colonoscopy?
Patients on anticoagulants will usually be advised of the modifications that are required to their medication regime at the time of the pre-assessment appointment.

What is the expected increase in demand on symptomatic colonoscopy services for the DHBs once the NBSP is introduced?
Data indicates an approximate 20 percent increase in demand over the first two years of bowel screening in a DHB. However, with increased publicity about bowel screening, this increase could occur earlier. It is anticipated that this will vary from DHB to DHB.

What are the time frames for the posting and receipt of the specimens and what happens if these are spoiled by the time they reach the lab?
Local postal systems have been tested from selected locations around New Zealand. The majority of samples are returned within the designated timeframe (seven days) for which the buffer in the FIT kit will minimise degradation of blood in the sample. All samples have an expiry date on the kit and these are checked at the lab before testing. No samples found to be over the expiry date are tested, ensuring all samples are within the recommended time frames for testing.

What happens to "spoiled" samples?
If the kit is spoiled, the NCC will automatically send a replacement kit. In the event of multiple spoilt kits being returned by a participant, the NCC will contact them and provide advice.
Some reasons kits are determined to be spoiled, include: not putting the correct bar codes on samples, family members mixing up bar codes, failing to sign consent form, failing to include the consent form with the kit. If the participant has lost the kit they can contact the NCC to be sent another one.

Is the "FIT" test the same as the commonly ordered iFOB?
The FIT or faecal immunochemical test is the term for the screening test being used in NBSP. Other tests for occult blood in faeces include the guaiac FOB (faecal occult blood) test. Immunochemical tests maybe also be referred to as iFOBT (immunochemical faecal occult blood test). These tests when used in a screening programme may use a different threshold for positivity.

The use of faecal occult blood testing outside the NBSP is not recommended because timely follow up investigations may not be guaranteed and the appropriate quality and equity safeguards are not in place. The use of faecal occult blood testing is not recommended for symptomatic patients who should be assessed according to the recommendations on regional health pathways and the direct access referral criteria for colonoscopy.

How is primary care paid for participants referred to colonoscopy?
GPs receive $60 per referral whether it is an "information referral" or a DHB colonoscopy referral. Individual DHBs will develop a payment mechanism for positive result referrals to the endoscopy unit.

Is there a reminder or alert system that primary care can use so they are able to identify who hasn't had a screen and take the opportunity to discuss bowel screening participation with a person?
There are various reminder tools available e.g. Dashboard and Patient Prompt among others. There is currently no national system. The Ministry is working with DHBs to look at possibilities.