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Draft NSW Colonoscopy Categorisation Clinical Practice Guide

Agency for Clinical Innovation

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Contents

NSW colonoscopy categorisation at a glance

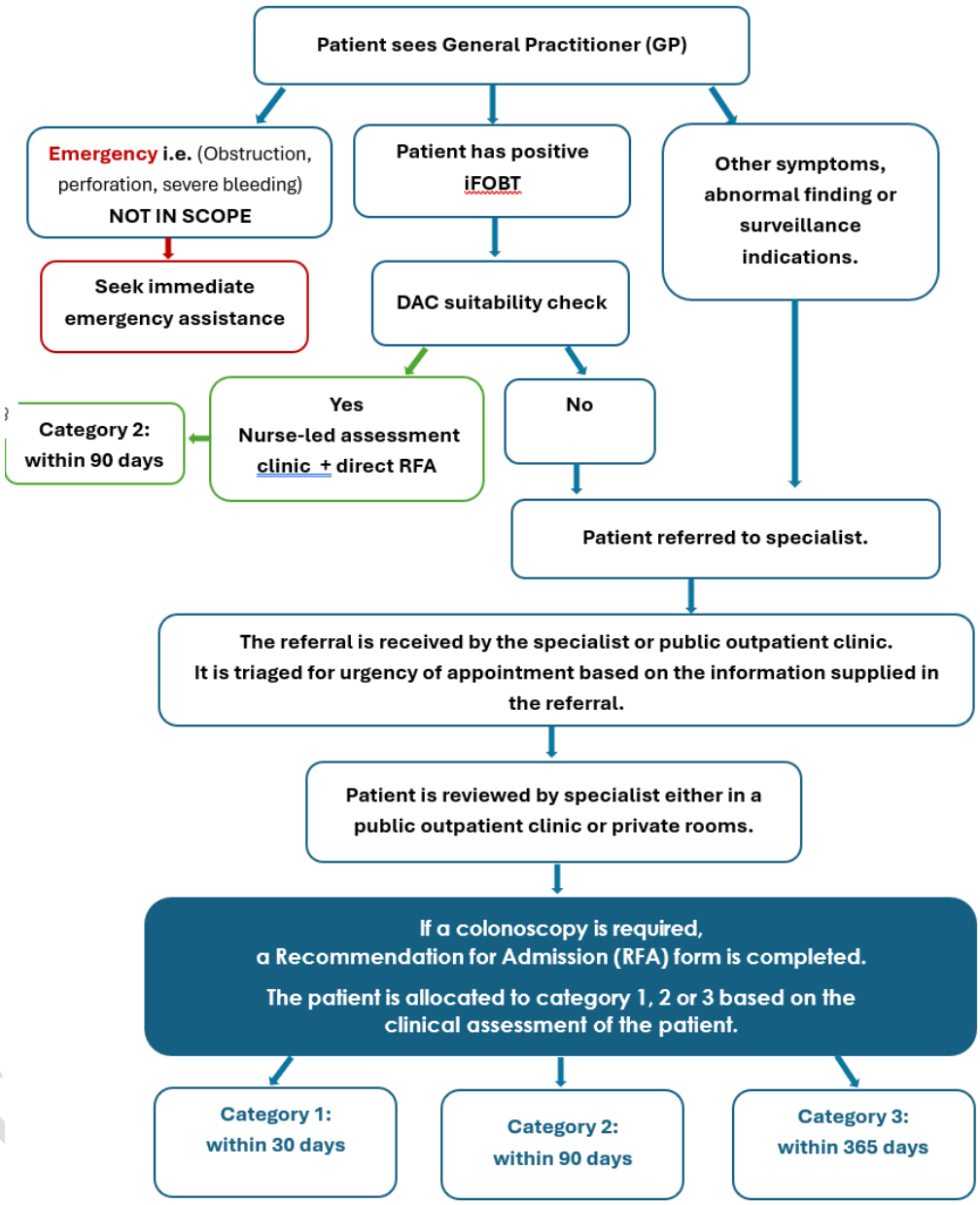
This Guide begins at the point where the patient and general practitioner (GP) determine that colonoscopy is the preferred investigation or treatment option and it reflects the patient's journey from that decision onward.

Categorisation and guidance are informed by available evidence, clinical consensus and alignment with the current NSW Health policy and the Colonoscopy Clinical Care Standard.

Clear communication of referral outcomes expected timeframes and colonoscopy results supports shared decision-making, continuity of care and appropriate surveillance planning.

Figure 1: NSW Health Colonoscopy Pathway

Note: Patients who require urgent intervention are excluded from the scope of this Guide.



[1] This document aligns with current national guidance and state policy, including:

- Australian Commission on safety and Quality in Healthcare **Colonoscopy Clinical Care Standard** (Revised 2025)
- **Planned Surgery Access 2025, (PD2025_036)**

Introduction

Background

This document revises the 2021 *Colonoscopy Categorisation Guide*, originally co-led by the Agency for Clinical Innovation (ACI) Gastroenterology and Surgical Care Networks and builds on earlier work undertaken in collaboration with the Cancer Institute NSW, Ministry of Health and other key stakeholders.

The guide is not intended to replace local decision-making. Implementation remains the responsibility of each local health district (LHD) and should be supported by locally agreed models of care and protocols.

Purpose

This clinical practice guide supports timely, safe and equitable access to colonoscopy across NSW public hospital services. As demand for colonoscopy continues to increase, there is a clear clinical need for evidence-informed criteria to prioritise patients according to risk and urgency. The guide aims to standardise triage and clinical priority categorisation, reduce unwarranted variation in practice, and improve consistency in referral and booking processes across local health districts. Implementation of this guide supports best practice decision-making for clinicians and services and improves patient outcomes by facilitating earlier diagnosis and appropriate follow-up for bowel cancer and other significant gastrointestinal conditions.

Objectives

This guide aims to:

- provide a consistent statewide framework for colonoscopy triage and clinical priority categorisation
- support clinicians to align clinical urgency with appropriate timeframes and pathways (e.g. outpatient review, direct access colonoscopy where available, surveillance)
- improve the quality and completeness of referral information to support safe and timely decision-making
- promote equitable access by reducing unwarranted variation in categorisation and booking practices
- strengthen communication of triage outcomes and expected timeframes to support shared decision-making and continuity of care.

High-quality, timely colonoscopy is critical for the early detection and treatment of bowel cancer and other gastrointestinal conditions. Increasing demand for colonoscopy services has created a need for clear consistent criteria to categorise and prioritise patients presenting to NSW public hospital colonoscopy services.

Scope

This guide applies from the point at which the patient and referring clinician (usually a GP) determine that colonoscopy is the preferred investigation or treatment option, through referral, triage and scheduling in NSW public hospital services. It is intended for gastroenterologists, surgeons, GP endoscopists, clinical nurse consultants and administrative and booking teams involved in managing access to colonoscopy services. Patients requiring urgent or emergency intervention are outside the scope of this guide and should be managed via local emergency pathways.

The *NSW Colonoscopy Categorisation Clinical Practice Guide* supports clinicians and health services to deliver

appropriate and timely colonoscopy in line with national evidence-based guidance and NSW Health policy for referral, triage and scheduling.

The guide aligns with and complements existing pathways, including the National Bowel Cancer Screening Program, the Cancer Institute NSW Direct Access Colonoscopy (DAC) pathway and the NSW Health Statewide Referral Criteria. It provides a consistent, evidence-based framework to support referral quality, triage and prioritisation for colonoscopy across NSW.

The DAC pathway enables eligible patients to be booked directly for colonoscopy without a prior specialist outpatient appointment, where available, improving timeliness and access to care.

The National Bowel Cancer Screening Program (NBCSP) identifies individuals at increased risk of bowel cancer through population screening using (**immunochemical faecal occult blood test** (iFOBT)). This guide supports health services to prioritise appropriate access to colonoscopy across NSW, including alignment with DAC pathways where available.

Priority categories

NSW public hospital colonoscopy services use three clinical priority categories for patients requiring colonoscopy. These categories align with the **NSW Planned Surgery Access Policy (PD2025_036)** with defined timeframe for access to colonoscopy:

- **Category 1**: within 30 days
- **Category 2**: within 90 days
- **Category 3**: within 365 days

Clinicians should assess referred patients against critical clinical factors (e.g. positive+ iFOBT, unexplained anaemia, rectal bleeding) and patient characteristics (e.g. age) and assign a clinical priority category accordingly (Table 3).

Where clinically appropriate, non-invasive tests such as iFOBT and faecal calprotectin may be used to support triage and prioritisation of patients awaiting colonoscopy. Patients who are staged, including those classified as Category 4 (Not Ready for Care), fall outside the routine Category 1–3 prioritisation timeframes. These patients should be managed in accordance with the NSW Health Planned Surgery Access Policy Directive (PD2025_036).

Under PD2025_036, staged patients remain on the waiting list but are not currently available for treatment for clinical reasons, or because their condition does not yet require, or is not yet suitable for, colonoscopy and will require treatment at a future date.

A *Not Ready for Care* patient is a subset of staged patients who are temporarily unavailable for admission for admission for clinical reasons and are therefore classified as *Staged – Not Ready for Care*.

This Guide excludes patients who require emergency intervention. These patients should be managed through local emergency pathways in accordance with NSW Health policy.

Change Summary

Alignment with key policy and standards:

- NSW Planned Surgery Access Policy (PD2025_036)
- Revised Colonoscopy Clinical Care Standard (2025).

Stronger referral and triage requirements and reinforce clear communication of triage outcomes to support safer and more consistent decision-making.

The scope and pathways have been clarified to support consistent use alongside:

- National Bowel Cancer Screening Program (NBCSP)
- Direct Access Colonoscopy (DAC)
- NSW Health Statewide Referral Criteria (SRC)

Improved equity, cultural safety, and inclusivity to support equitable access and culturally safe, inclusive care, aiming to reduce barriers and variation in patient experience and outcomes.

Changes reflect updated evidence and stakeholder feedback

Intended system impact to reduce unwarranted variation, support more reliable prioritisation and follow-up, and improve the timeliness and quality of colonoscopy care across NSW.

Method

This section outlines the methods used to develop and update this edition of the NSW Colonoscopy Categorisation Clinical Practice Guide. The guide was developed in accordance with ACI best practice for clinical guidance processes, using a structured approach that included, multidisciplinary consultation and iterative drafting to support transparent, consistent and evidence informed recommendations.

Evidence gathering (literature and policy review)

A targeted literature review was undertaken to identify contemporary evidence relevant to colonoscopy triage, access and timeliness. This included assessment of critical factors relevant to prioritisation (e.g. positive iFOBT, rectal bleeding, anaemia), surveillance intervals, and the use of bidirectional endoscopy. Searches focused on literature published from 2020 to 2026 and were conducted in PubMed as well as Australian guideline repositories and relevant organisational websites (e.g. ACSQHC, Cancer Council Australia, NHMRC) and NSW Health policy and directive sources. Reference lists of key guidelines and high-impact studies were screened to identify additional relevant publications.

Inclusion and exclusion criteria

Evidence was prioritised according to relevance to the NSW public health system and applicability to adult colonoscopy services, with emphasis on:

- current national and international clinical practice guidelines and standards
- systematic reviews and meta-analyses
- high-quality observational studies relevant to time-to-colonoscopy and patient outcomes
- NSW Health and Commonwealth policy and program requirements relevant to referral, booking, reporting and follow-up.

Evidence was excluded where it was not relevant to colonoscopy triage or categorisation, focused on paediatric populations, related solely to emergency presentations (outside the scope of this guide), or where findings had been superseded by more recent higher-quality evidence.

Considerations for culturally safe care

Care should be sensitive to cultural, religious and interpersonal differences, including but not limited to, sexual orientation, gender identity and physical and intellectual abilities. As colonoscopy is a sensitive and invasive procedure, clinicians should:

- use clear, respectful communication.
- seek and respect patient preferences (including clinician gender where possible)
- provide culturally safe, trauma-informed care.

Engage a professional interpreter service for individuals, their partners or support people who are deaf and hard of hearing, or from culturally and linguistically diverse backgrounds.

Providing care in a culturally safe, inclusive and responsive is essential to improving access, experience and outcomes.

People requiring colonoscopy may identify as men, women, or with other gender identities. Consistent with ACI principles and expert guidance, this document uses the term “patients” throughout to describe individuals who may require colonoscopy. The language used will continue to evolve through consultation with clinical, consumer, and community representatives to ensure it remains inclusive.

Aboriginal and Torres Strait Islander peoples

The ACI acknowledges we are located on the lands of the Cammeraygal people and the many Aboriginal Nations whose lands we work across. We are committed to embedding cultural protocols, listening to diverse Aboriginal perspectives, and prioritising initiatives that improve health outcomes and close the gap between Aboriginal and non-Aboriginal people.

Health outcomes for Aboriginal and Torres Strait Islander peoples can be improved through health systems that acknowledge and address historical and ongoing factors that influence access to care. These include experiences of systemic racism, lack of culturally safe and responsive care, limited access to culturally appropriate health information, and the broader social and cultural determinants of health.

For patients identifying as Aboriginal, the inclusion of Aboriginal Health Workers and Aboriginal Liaison Officers in care pathways is critical. They help promote cultural safety, assist with navigating the health system, advocate for patient needs, and facilitate effective communication.

This includes consideration of the enduring impacts of historical policies on access to healthcare, knowledge of family history, trust in health services, and the importance of informed, culturally safe care.

Discussions relating to symptomology requiring colonoscopy may be considered sensitive for many Aboriginal people and for women, may be recognised as Women’s Business and should be approached with privacy and respect. Where possible, offer care from female clinicians to support cultural preferences.

Clinicians should take time to yarn with patients and engage in respectful, open conversations about their care. This helps understand individual preferences, avoid assumptions, and, where appropriate, involve family or community supports. These discussions should:

- Be guided by what is important to the patient.
- Be informed by best clinical practice.
- Use plain language and culturally appropriate resources.

Shared decision-making is important when making decisions in health care. The **Finding Your Way** shared decision-making model is a holistic, two-way process where Aboriginal people and clinicians make decisions together.

Care of Culturally and Linguistically Diverse people

It is recommended that all care providers:

- Use interpreter services for all families and carers where English is not their first language.
- Provide written information in the preferred language of the family or carer (where available).
- Use additional services, such as multicultural liaison officers, to support and inform families.

Care of LGBTIQ+ people

It is recommended that all care providers:

- Create an environment where the person feels safe to share what language best describes themselves, their health care experiences and needs, relationships and family or support network.
- Use appropriate pronouns, language and terminology about bodies, sexuality, gender, and intersex variations as this supports recognition, trust, and safety.

Care of patients with an intellectual and/or physical disability

It is recommended that all care providers:

- Promote dignity, autonomy and inclusion, ensuring that care is respectful, non-discriminatory and tailored to the patient's developmental and functional abilities.
- Engage with the patient and their family or carers to understand their individual strengths, needs, and preferences.
- Use communication aids or alternative communication methods (e.g., visual supports, simplified language, assistive technology) to ensure the patient and their carers can understand and participate in care.

Links to resources

- **Finding your way**
- **Colonoscopy resources for Aboriginal and Torres Strait Islander peoples**
- **Bowel screening for our Mob**
- **Stolen Generations Survivors action plan 2025-2030 Towards Health and Healing**
- **Multicultural Health Communication service**
- **LGBTQI+ Health**
- **LGBTIQ+ language and terminology including pronouns**
- **ACON Colonoscopy care for gender diverse people**

NSW Colonoscopy Categorisation Criteria

Table 1 outlines colonoscopy categorisation criteria based on critical factors to support clinical prioritisation and booking. Booking should reflect guidelines, colorectal-based timeliness and be supported by a locally approved policy.

Further detail to support interpretation and application of these criteria is provided in the sections below, *Clinical guidance to support colonoscopy categorisation and prioritisation*.

The categorisation framework is designed to support consistent and clinically appropriate prioritisation of colonoscopy referrals by balancing the likelihood of significant colorectal pathology against the urgency of investigation. Critical factors act as modifiers that increase concern for underlying serious disease, particularly colorectal cancer, and influence whether a patient is allocated to Category 1, 2, or 3.

The key critical factors include:

- Positive immunochemical faecal occult blood test (+iFOBT)
- Unexplained iron deficiency or anaemia
- Rectal bleeding
- Altered bowel habit (>6 weeks and <12 months)
- Age ≥45

These factors should not be interpreted in isolation. Categorisation should consider the combination of symptoms, age, symptom duration, and overall clinical context. A symptom occurring in a low-risk setting may warrant lower priority investigation, whereas the same symptom in combination with other critical factors substantially increases the likelihood of significant organic pathology and may warrant expedited colonoscopy.

If an NBCSP participant has a positive iFOBT or a patient aged ≥ 45 years has positive iFOBT, clinicians should refer the patient to a DAC service where available and clinically appropriate. If DAC is not available or suitable, the patient should be prioritised for outpatient review (clinic or consultant rooms). In the absence of other critical factors, these patients should be categorised as Category 2 on the Referral for Admission (RFA) (see Table 2).

Studies show that delays greater than 9 months between a positive iFOBT result and colonoscopy are associated with an increased risk of more advanced stage colorectal cancer at diagnosis. Clinicians should therefore prioritise patients with a positive iFOBT for definitive investigation, either via a DAC pathway or specialist consultation (Forbes et al, 2020; Corley et al, 2017).

A series of practical clinical scenarios illustrating the application of these criteria can be found in Appendix 2. Readers are encouraged to refer to the appendix for detailed examples of categorisation and prioritisation in real-world contexts.

Table 1. NSW Colonoscopy Categorisation Criteria

Critical Factors	Category 1: <30 days	Category 2: <90 days	Category 3: <365 days (including surveillance
NSW Ministry of Health definition of category	**Procedure** within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency OR **Admission** within 30 days. High likelihood of significant organic pathology. Admission within 30 days desirable for conditions likely to deteriorate.	**Procedure** within 90 days desirable for a condition which is not likely to deteriorate quickly or become an emergency OR **Admission** within 90 days lower likelihood of significant organic pathology or deterioration.	Patients who are unlikely to deteriorate quickly and which have little potential to become an emergency ***Please Note:*** *overdue patients may warrant reassessment based on updated risk assessment.*
1.+iFOBT	+iFOBT AND presence of any other critical factors	+iFOBT AND no other critical factors (including NBCSP patients)	
2. Unexplained iron deficiency or unexplained anaemia	Unexplained iron deficiency **OR** unexplained anaemia **AND** any other critical factor* Colonoscopy may be offered to premenopausal people after specialist assessment and consideration of other causes of IDA, including gynaecological causes and frequent blood donation. (refer to **GESA/RACS BDE Statement, 2024**)	Iron deficiency with no other critical factors*	
3.Rectal bleeding	Rectal bleeding AND any one of: Any other critical factor **OR** <12 months duration, age⩾45 years	Rectal bleeding <12 months duration **AND** age <45 years **AND**	Rectal bleeding >12 months

	OR <12 months duration, age < 45 years and any other symptom	no other critical factor* or other symptom (note: Local anorectal examination and investigation may be appropriate. **https://www.gesa.org.au/public/13/files/Education %26 Resources/Position Statements/GESA BDE Position Statement 2024.pdf**	
4. Altered bowel habit	Altered bowel habit (>6 weeks and <12 months) **AND** any critical factor*	Altered bowel habit (>6 weeks and <12 months) AND no critical factor*	
5. Unexplained significant weight loss	Unexplained significant weight loss **AND** any critical factor*	Unexplained weight loss AND no other critical factor	
6. Unexplained abdominal pain		Unexplained abdominal pain **AND** any critical factor* Consider cross-sectional imaging where clinically appropriate	Unexplained abdominal pain **AND** no critical factor*
7. Mass	Palpable rectal or abdominal mass **OR** mass present on rigid/flexible sigmoidoscopy **OR** likely colorectal mass on imaging (including PET)		
8. Adenocarcinoma of unknown primary	Adenocarcinoma of unknown primary		

9. Colorectal cancer surveillance (post colon cancer resection)		Post colorectal resection with: • incomplete colonoscopy or • incomplete clearance of polyps preoperatively. Complete examination of colon (if not d one preoperatively)	Other surveillance post cancer surgery as per NHMRC guidelines intervals
10.Family History Clinicians should be aware that some Aboriginal and Torres Strait Islander peoples may have limited access to, or knowledge of, family medical history due to the impacts of past and ongoing policies and practices, including the Stolen Generations. Where family history is unavailable or incomplete, this **should not disadvantage patients in clinical assessment, referral or prioritisation decisions.** For information about the Stolen Generations and practical tools on trauma-informed practice see **The NSW Health Integrated Trauma-Informed Care Framework**.			
			Family history–based screening and colonoscopy intervals should follow the NHMRC endorsed Clinical Practice Guidelines for risk and screening based on family history Clinical Practice Guidelines for the prevention, early detection and management of colorectal cancer – Risk and screening based on family history

11. Polyp management and surveillance Note: **Bidirectional endoscopy guidance** Approved Interactive tool: **Clinician decision support tool Polyp guide**	See Table 4. Surveillance recommendations for individuals age ⩾75 years table below	Polyps requiring referral for excision or incomplete polypectomy (urgency of incomplete polyp excision depends on individual clinical factors and polyp features and may allow clinical upgrading to Cat 1) See Table 4. Surveillance recommendations for individuals age ⩾75 years table below	Surveillance colonoscopy after polyp ectomy (refer to current *NHMRC Clinical Practice Guidelines for surveillance Colonoscopy* section: *Colonoscopic surveillance after polypectomy*) See Table 4. Surveillance recommendations for individuals age ≥75 years table below
12. Suspected inflammatory bowel disease (IBD)	Suspected IBD **AND** any one of: • calprotectin above 250mcg/ • raised C-reactive protein or erythrocyte sedimentation rate • iron deficiency • low albumin • abnormal rigid/flexible sigmoidoscopy	Suspected IBD without critical factors	Surveillance procedure (refer to current NHMRC *Clinical Practice Guidelines for Surveillance Colonoscopy* (section: *Colonoscopic surveillance and management of dysplasia in inflammatory bowel disease*)

Table 2. Surveillance recommendations for individuals age ⩾ 75 years

Reference: Cancer Council Clinical practice guidelines for the prevention, early detection and management of colorectal cancer (Table 17)

Age (years)	Charlston Score [a]	
	⩽4	>4
75-80	Surveillance colonoscopy to be considered [b,c]	Surveillance colonoscopy not recommended
>80	Surveillance colonoscopy not recommended	

[a]Charlson for colonoscopy benefit can be simplified as per Table 18; [b]colonoscopy should be considered an option dependent on a clear conversation about the low risk of significant colorectal pathology, taking the patient's wishes into consideration; [c]consent for colonoscopy should include age-appropriate statistics on risk

Detailed clinical guidance to support colonoscopy categorisation

The following section provides detailed guidance to support interpretation and application of the colonoscopy categorisation criteria outlined above. This includes rationale for prioritisation decisions, clarification of critical factors, recommended timeframes, and considerations for specific clinical scenarios.

Critical factors for categorisation

Certain clinical findings are associated with an increased likelihood of clinically significant colorectal pathology. Critical factors are not diagnostic in isolation and should be interpreted in the context of the patient's overall clinical presentation. When present, particularly in combination with gastrointestinal symptoms, they increase the probability of significant pathology and may influence the urgency of colonoscopy categorisation.

Patients referred for colonoscopy should be assessed using critical factors and other relevant clinical context. These support clinicians in determining the appropriate clinical priority category.

Clinically appropriate +iFOBT

In addition to its established role in population screening, evidence supports the selective use of iFOBT in the assessment of symptomatic patients.

Unexplained anaemia

Anaemia is associated with an increased likelihood of colorectal cancer, with a reported positive predictive value (PPV) of 9.7% (3.5-27). This association is not limited to iron deficiency anaemia.

In premenopausal people other causes of anaemia, including gynaecological conditions and frequent blood donation should be considered as part of specialist assessment prior to referral for colonoscopy.

For more info see: **Value-based Surgery – Hysterectomy for heavy menstrual bleeding**

Rectal bleeding

Rectal bleeding alone has a PPV of approximately 2.4% for colorectal cancer, with risk increasing when additional factors are present, such as increasing age or new onset of bleeding. The exact nature of the bleeding is subjective, for the purposes of this Guide, all rectal bleeding is considered clinically relevant.

Digital rectal examination should be regarded as a mandatory component of assessment in all patients presenting with rectal bleeding.

In a patient with prolonged (>12 months) bright red rectal bleeding without other symptoms, and particularly in those under 45 years of age, it may be reasonable to consider flexible sigmoidoscopy and management of an identified benign cause (such as haemorrhoids) prior to proceeding to full colonoscopy. In these circumstances:

- clinicians should explain that other causes, including malignancy have not been definitively excluded
- close follow-up and reassessment by the treating clinician is required

Age is an independent risk

While the risk of colorectal cancer increases with age, and the incidence of early-onset colorectal cancer (diagnosed under 50 years) has been rising, it is important to emphasise that the absolute risk in younger

individuals remains low. In Australia, early-onset colorectal cancer accounts for approximately 8% of new cases.

Population-level data also demonstrates a decline in colorectal cancer incidence in individuals aged over 50 following the introduction of the National Bowel Cancer Screening Program (NBCSP), highlighting the effectiveness of organised screening. Current Cancer Council Australia guidelines recommend screening in individuals aged 45–74 years, reflecting both the rising incidence in younger cohorts and the overall balance of risk and benefit.

Overall, while the likelihood of colorectal cancer in those under 50 years remains relatively low, persistent or unexplained gastrointestinal symptoms warrant timely specialist assessment to exclude significant pathology.

Unexplained weight loss

Unexplained weight loss greater than 10% may be associated with significant gastrointestinal pathology, including colorectal cancer, particularly when accompanied by additional critical factors such as anaemia, rectal bleeding, altered bowel habit, or increasing age. The positive predictive value of isolated unexplained weight loss for colorectal cancer is relatively low, but increases substantially in the presence of other concerning clinical features.

Altered bowel habit (>6 weeks and <12 months)

The predictive value of altered bowel habit alone for colorectal cancer is relatively low in younger individuals without additional risk factors. The use of non-invasive investigations, such as iFOBT and faecal calprotectin, is suggested in the assessment of these individuals. Symptoms of short duration or fluctuating longstanding symptoms without additional concerning features are less likely to reflect significant colorectal pathology.

Persistent unexplained altered bowel habit should be assessed in the context of the overall clinical presentation and may warrant colonoscopy where symptoms are ongoing or associated with additional critical factors.

Palpable abdominal or rectal mass abnormal imaging suggestive of colorectal pathology.

A palpable abdominal or rectal mass, or abnormal imaging suggestive of colorectal pathology, is associated with a high likelihood of significant organic disease and warrants urgent further investigation with colonoscopy.

Assessment prior to colonoscopy referral

An appropriate clinical assessment should be completed by the referring clinician prior to referral for colonoscopy. The assessment may include:

- clinical history
    - presenting symptoms
    - relevant medical history, including current medications
- physical examination, where indicated
- appropriate investigations, such as:
    - full blood count, ferritin, iFOBT (in symptomatic patients, where clinically appropriate)
- previous colonoscopy reports and histology if available
    - where prior reports or histology are unavailable, this should be documented and should not disadvantage patients during clinical assessment or prioritisation.

Where referral to an outpatient or DAC service is appropriate, the relevant NSW Health Statewide Referral Criteria form should be completed.

Note: Use of the Adult Gastroenterology Statewide Referral Criteria is recommended to support referral completeness and facilitate appropriate triage.

Colonoscopy clinical priority categorisation process

Assignment of a clinical priority category is recorded on the Recommendation for Admission (RFA) form.

The RFA should include the proposed Medicare Benefits Schedule (MBS) item number to support National Weighted Activity Unit (NWAU) assessment and audit. Relevant Investigations that informed assigned clinical priority category should be attached to the RFA.

In NSW public hospital colonoscopy services, clinical priority Categories 1, 2 and 3 correspond to procedures recommended within 30, 90, or 365 days respectively from the date the RFA or referral for colonoscopy is received.

Table 3. Clinical priority categories

Clinical priority category *A clinical assessment of the priority with which a patient requires elective admission#*	
Category 1	Procedure clinically indicated within **30 days**
Category 2	Procedure clinically indicated within **90 days**
Category 3	Procedure clinically indicated within **365 days**

 # Patients requiring urgent intervention are outside the scope of this Guide, booking should reflect guideline-based timeliness and be supported by a locally approved policy.

The date stamped on the RFA by the receiving booking officer is the listing date, which starts the waitlist period; patients must be added to the waitlist within 3 working days and managed in turn based on clinical urgency to ensure equitable access regardless of referral source or insurance status. Public patients are allocated to a clinician by the hospital (which may differ from the referring doctor), and categorisation may be undertaken by suitably qualified clinicians and/or appropriately skilled waiting list managers.

Please refer to the NSW Health Planned Surgery Access Policy Directive (PD2025_036) for detailed information about the clinical priority categorisation process.

Rationale for multiple colonoscopy timeframes

Triaging colonoscopies referrals is necessary to ensure that at higher risk patient cohorts receive timely care and that the opportunity cost and potential clinical risk associated with delay are minimised. The use of defined timelines provides clinicians with guidance on appropriate categorisation, informed by peer reviewed guidelines and the available evidence base. Colonoscopy categorisation is supported by evidence indicating a low risk of progression in colorectal cancer stage when diagnostic colonoscopy occurs within the recommended timeframes for specific clinical scenarios.

There are multiple presentations in which clinical priority must be determined, including iFOBT and other risk factors. Suggested categorisation aligned to common clinical scenarios are described later in this document.

Recommended timeframes also take into account the time elapses between initial GP referral, specialist review and categorisation and submission of the RFA. In addition, the potential psychological impact on patients while awaiting investigations to exclude malignancy was considered during development of this Guide.

Bidirectional endoscopy

Bidirectional endoscopy (BDE), defined as same-day upper and lower gastrointestinal endoscopy, is often performed to evaluate gastrointestinal presentations and abnormalities. There are established indications for which BDE is clinically appropriate, supported by literature and considered cost-effective. However, when used

inappropriately, it may result in risks to the patient that are greater than the benefits and disproportionate to the costs. Gastroscopy without an indication or low-value gastroscopy combined with colonoscopy should be avoided.

BDE should only be performed when there is a clear and appropriate indication for both upper and lower endoscopy and when combining the procedures is clinically justified.

A joint position statement from the Gastroenterology Society of Australia (GESA) and Royal Australasian College of Surgeons (RACS) outlines scenarios in which BDE may be appropriate. Key recommendations are summarised in table 4.

Table 4: Summary of recommendations for bidirectional endoscopy (BDE)

BDE is STRONGLY recommended based on current guidelines	BDE MAY be recommended based on clinical review	BDE is NOT routinely recommended
• Iron deficiency anaemia or persistent unexplained iron deficiency • Assessment and surveillance of polyposis and inherited cancer syndromes	• Chronic diarrhoea • Inflammatory bowel disease • Unintentional weight loss • Metastatic malignancy with unknown primary • Surveillance procedures • Patients living in rural and remote areas • Patients with clinically appropriate indications for both upper and lower endoscopy	• Routine gastroscopy testing for Helicobacter pylori in a patient referred for colonoscopy • Positive results of faecal immunochemical test for immunohistochemical faecal occult blood test without upper gastrointestinal symptoms • Routine screening for Barrett's oesophagus in a patient referred for colonoscopy • Non-specific abdominal pain • Any scenario where endoscopy is not indicated or has low clinical value and yield

Source: GESA/RACS, 2024

Surveillance colonoscopy categorisation

For guidance on surveillance colonoscopy, refer to **Clinical Practice Guidelines for Surveillance Colonoscopy (2019)**, which are approved by the National Health and Medical Research Council (NHMRC). Patients referred for surveillance colonoscopy earlier than the recommended interval should be assessed for the presence of new symptoms, laboratory abnormalities, family history and the quality of the previous colonoscopy (where available). In the absence of new findings or other modifying factors, these patients should be referred to their GP for ongoing monitoring and scheduled for surveillance colonoscopy at the appropriate interval.

Recommended surveillance intervals may vary depending on the quality of a previous colonoscopy, including factors such as bowel preparation quality and colonoscopist performance.

In general, surveillance colonoscopy should be categorised as Category 3 in the absence of new critical symptoms or findings.

Update to Information recording and sharing:

Services should communicate referral outcomes and planned timeframes to referring clinician promptly to support shared decision-making and manage patient expectations.

Services should record outcomes and recommendations in facility records and shared record systems (e.g., My Health Record). For National Bowel Cancer Screening Program participants, services should report colonoscopy outcomes to the National Cancer Screening Register (NCSR).

Refer to **The Colonoscopy Clinical Care Standard (2025)**, “the Standard”, **Quality statement 1**, for required referral documentation.

Refer to the Standard, Statement 4, for bowel preparation recommendations.

Refer to the Standard, Quality statement 7, for considerations to reduce unwarranted clinical variation. Use a validated bowel preparation assessment tool (e.g., Boston, Ottawa, Aronchick) and record the score for every colonoscopy to support service-level monitoring.

Statewide digital platforms such as the SDPR can help deliver the intent of the Colonoscopy Clinical Care Standard (2025) for information recording and sharing by improving access to colonoscopy findings, recommendations and surveillance history across services. Ready access to prior colonoscopy details supports correct surveillance interval decisions, reduces clinical risk, and helps avoid unnecessary or early repeat requests that add pressure to waitlists. Use of SDPR is subject to local access and implementation.

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Glossary

Term, acronym or abbreviation	Definition/Description
Colonoscopy	Diagnostic/therapeutic examination of the colon with a colonoscope
CCCS	Colonoscopy Clinical Care standard (Australian Commission)
CCSG	Colonoscopy Categorisation Steering Group
CCWG	Colonoscopy Categorisation Working Group
CPC	Clinical priority category
CRC	Colorectal cancer
CRP	C-reactive protein
DAC	Direct access colonoscopy, a clinical initiative of the Leading Better Value Care program otherwise known as Open Access colonoscopy
IBD	Inflammatory bowel disease
IDA	Iron deficiency anaemia
iFOBT	Immunochemical faecal occult blood test (also known as faecal immunochemical test or FIT)
LHD	Local health district
MCH	Mean corpuscular haemoglobin
MCV	Mean corpuscular volume
NBCSP	National Bowel Cancer Screening Program
NHMRC	National Health & Medical Research Council
PET	Positron emission tomography
PPV	Positive predictive value
RFA	Request for admission
Screening	Investigation of an individual at standard risk of a condition, usually defined as a single time-point
Surveillance	The longitudinal investigation of an individual with respect to a condition. The use of this term in colorectal cancer usually implies increased risk for that individual
the Guide	NSW Colonoscopy Categorisation Clinical Practice Guide

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Appendix 1: Detailed change summary

This edition updates and expands the NSW Colonoscopy Categorisation Clinical Practice Guide to align with the NSW Planned Surgery Access Policy (PD2025_036) and the revised Colonoscopy Clinical Care Standard (2025), strengthening referral requirements, documentation and communication of triage outcomes. The scope and pathways are clarified to support consistent use alongside the National Bowel Cancer Screening Program, Direct Access Colonoscopy (DAC) and Statewide Referral Criteria (SRC) , with added guidance to improve equity and culturally safe, inclusive care. These changes reflect updated evidence and stakeholder feedback and are intended to reduce unwarranted variation, support more reliable prioritisation and followup, and improve timeliness and quality of care for patients.

Table 1: How statewide and national pathways work together to support colonoscopy access in NSW

Program / pathway	What it does	How it works with the ACI Colonoscopy Categorisation Clinical Practice Guide
National Bowel Cancer Screening Program (NBCSP)	Identifies people at increased risk of bowel cancer through population screening using immunochemical faecal occult blood test (iFOBT)	Supports triage and prioritisation for diagnostic colonoscopy following a positive iFOBT, promoting timely and equitable access across NSW.
Cancer Institute NSW Direct Access Colonoscopy (DAC)	Enables eligible patients to be referred and booked directly for colonoscopy (without a prior specialist clinic visit), improving timeliness and access.	Aligns with DAC by supporting consistent clinical categorisation and prioritisation, so appropriate patients are triaged and booked to the right timeframe.
NSW Health Statewide Referral Criteria (SRC)	Supports consistent, high-quality referrals by outlining the information required for triage.	Uses SRC referral information to support consistent categorisation and prioritisation, and to allocate patients to DAC, outpatient review or surveillance pathways.

Table 2: Change Summary for full table of changes to the updated Colonoscopy Categorisation document.

Topic / Section	Original Guidance (High-Level)	Updated Guidance (March 2026)	Nature of Change	Evidence / Policy Alignment	Practical Impact
Scope of the guide	Explicitly stated: patients who require urgent intervention are excluded from scope	Explicit exclusion of patients requiring urgent or emergency intervention, with clearer linkage to emergency pathways	Clarification	NSW Health planned surgery and emergency pathways	Reduces misapplication of planned categories to emergency cases
Alignment with NSW policy	Aligned to NSW planned surgery category timeframes/definitions (using NSW Ministry of Health category definitions in criteria)	Explicit alignment with PD2025_036 Planned Surgery Access Policy and definitions (including Staged / NRFC)	Policy alignment	Updated NSW Health policy (PD2025_036)	Improves governance consistency and reduces categorisation confusion
Use of Colonoscopy Clinical Care Standard	Not referenced (predates 2025 revised standard)	Explicit cross referencing to Colonoscopy Clinical Care Standard (Revised 2025), incl. Quality Statements	Evidence & standards alignment	ACSQHC Colonoscopy Clinical Care Standard (2025)	Strengthens national consistency and defensibility
Referral information & communication	General expectation of referral and triage through outpatient processes; limited explicit minimum data requirements	Clear expectation for minimum referral information and timely communication of triage outcomes	Strengthening / clarification	ACSQHC CCS Quality statement 1; GPAG feedback	Improves referral quality and GP/patient expectation management
Use of Statewide Referral Criteria (SRC)	Not addressed	Explicit recommendation and hyperlink to SRC forms	New content / clarification	NSW Health SRC	Supports consistent triage and reduces inappropriate demand
Information recording & sharing	Not addressed	Explicit guidance on recording outcomes in facility systems, My Health Record and NCSR (for NBCSP participants)	New content	ACSQHC CCS (2025)	Improves continuity of care and reporting

Cultural safety and inclusive care	Not included	New, explicit section on culturally safe, trauma informed and inclusive care (incl. Aboriginal peoples, gender diversity)	New content	NSW Health policy; ACSQHC resources	Improves equity and patient centred care
Critical factors	Uses “critical factors” (criteria extract) and supporting clinical judgement; less emphasis on a defined “critical features” section	Refined and standardised definition of critical factors, used consistently across tables and scenarios	Clarification	Contemporary evidence synthesis	Improves consistency in categorisation decisions
iFOBT use in symptomatic patients	iFOBT included as a factor; limited explicit guidance on using iFOBT to down-/up-triage symptomatic patients	Explicit use of clinically appropriate iFOBT to support prioritisation in symptomatic patients	Evidence-informed refinement	Corley et al.; Forbes et al.; ACSQHC CCS	Supports risk-based prioritisation and demand stewardship
Age thresholds	Uses age cut-offs in criteria (e.g. 45 years for rectal bleeding scenario)	Clearer guidance around age (e.g. ≥45 years) in context of symptoms and iFOBT	Clarification	Cancer Council / NHMRC guidance	Reduces ambiguity for younger patients
Rectal bleeding assessment	Discusses local investigation may be appropriate in prolonged bleeding in younger patients; Digital rectal examination not explicitly mandated	Digital rectal examination explicitly stated as essential and not replaced by referral	Clarification	Clinical consensus / good practice	Reinforces appropriate examination and safer triage
Staged / NRFC patients	Identified as part of Category 3 definition text (staged/not ready for care referenced via older policy directive)	Explicitly excluded from Category 1–3 and referred to PD2025_036	Clarification	Planned Surgery Access Policy (PD2025_036)	Prevents mis categorisation and reporting errors

Surveillance colonoscopy	Surveillance included within Category 3; limited direction to national surveillance guidance/tools	Clear direction to NHMRC-endorsed Surveillance Colonoscopy Guidelines and use of polyp guide	Evidence alignment	NHMRC-endorsed surveillance guidance; endorsed CDS tool	Reduces low value early surveillance
Older patients (⩾75 years)	Not addressed	Inclusion of Table 17 with age and comorbidity based surveillance recommendations	New evidence based guidance	NHMRC surveillance guidance	Supports shared decision making and avoids harm
Polyp management	Not addressed	Clearer linkage to NHMRC surveillance guidance and GESA/RACS BDE statement (2024)	New content / alignment	GESA/RACS; NHMRC	Improves consistency of follow up and procedure planning
Bidirectional endoscopy (BDE)	Not addressed	Explicit guidance referencing GESA/RACS BDE position statement (2024)	New evidence based guidance	GESA/RACS BDE position statement (2024)	Reduces inappropriate combined procedures
Diverticulitis	Not addressed	Shift to selective colonoscopy following uncomplicated diverticulitis	New evidence based guidance	Contemporary guidelines	Reduces unnecessary procedures
Role of DAC & NBCSP	Not addressed	Clear articulation of how DAC, NBCSP and the Guide work together	New content / clarification	Cancer Institute NSW DAC model; NBCSP	Supports appropriate pathway use and triage consistency

Note: “original” refers to the Agency for Clinical Innovation’s (ACI) 2020 publication **NSW Colonoscopy Categorisation Clinical Practice Guide**

Appendix 2: Clinical scenarios

The following clinical scenarios present examples of critical factor categorisation and other symptoms:

Clinical Scenario 1

Clinically appropriate +iFOBT in absence of critical symptoms

The categorisation (Category 2) for colonoscopies is supported by evidence suggesting there is a low risk for change in cancer stage when the colorectal cancer is identified within this timeframe, where the time to consultation and submission of the RFA does not exceed 30 days.

+iFOBT is the currently recommended screening stool test for the detection of colorectal cancer with a sensitivity of 79% (69-86) and specificity of 94% (92-95).

The negative predictive value of -iFOBT is somewhat reassuring, at about 99%. The presence of a -iFOBT does not eliminate the possibility of colorectal cancer and should not rule out colonoscopy, particularly if other critical factors or symptoms are present. An -iFOBT however, may influence the prioritisation category.

NOTE: The iFOBT does not test for upper gastrointestinal blood loss.

Clinical Scenario 2

Unexplained iron deficiency or unexplained anaemia

Alternative explanations for iron deficiency or anaemia should be considered and possibly treated prior to referral for colonoscopy especially in pre-menopausal people.

If a cause for iron deficiency or anaemia is not identified, or if treatment has not been successful, then the patient should be referred for consideration of colonoscopy. Prioritisation will depend on critical factors or other symptoms

Unexplained anaemia has been shown to have a PPV for colorectal cancer of 9.7% (3.5-27).

This association is not restricted to iron deficiency. In one study 18% of patients with colorectal cancer had normocytic anaemia.

Clinical Scenario 3

Rectal bleeding

Rectal bleeding is a predictor of colorectal cancer and a critical factor. Colonoscopy should be performed for bleeding not previously investigated or new onset or new pattern of rectal bleeding.

Rectal bleeding alone has a PPV of ~2.4% for colorectal cancer. The likelihood of colorectal cancer is increased further if additional critical factors or other symptoms are present, such as advanced age, change in bowel habit or weight loss.

The role of digital rectal examination is essential. It should be performed in all patients presenting with rectal bleeding.

Rectal bleeding that has been present for >12 months and if present in patients under age 45, in the absence of any other signs or symptoms is less likely to be due to colorectal cancer.

Clinical Scenario 4

Altered bowel habit

Altered bowel habit is any change from the patient's usual pattern of bowel motions. Examples are diarrhoea, constipation or a feeling of incomplete evacuation persisting for longer than six weeks.

Defining significantly altered bowel habit requires clinical judgement. Changes for <6 weeks may be related to other factors, such as infection, dietary change, stress or new medications. Changes (especially constipation) present for >12 months are unlikely related to colorectal cancerThe presence of critical factors or other symptoms may lead to a change in prioritisation category.(Value Based Surgery CPG, 2023)

Additional tests may be obtained to help estimate the priority, as this presentation can have a large differential diagnosis. iFOBT, full blood count and faecal calprotectin (FCP) may contribute to the estimate of urgency to colonoscopy.

Clinical Scenario 5

Unexplained abdominal pain (SRC Criteria)

There is a range of other abdominal and non- abdominal conditions that may explain abdominal pain. Therefore, the term 'unexplained' is central to the consideration of this scenario.

Clinical judgement is important when assessing patients presenting with abdominal pain. Abdominal pain has a PPV for colorectal cancer of 3.3% (0.7–16%).

Consideration should be given to additional investigations, including breath tests, blood tests, cross-sectional imaging, and stool-based tests, where clinically appropriate.

Clinical Scenario 6

Uncomplicated diverticulitis confirmed on cross-sectional imaging

Australian recommendations for colonoscopy following diverticulitis recommend selective investigation rather than routine check colonoscopy.

Colonoscopy is recommended for all patients with complicated diverticulitis 6 weeks after CT diagnosis of inflammation, and for patients with uncomplicated diverticulitis who have suspicious features on CT scan or who otherwise meet national bowel cancer screening criteria.