Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Public consultation on the draft health technology assessment of extending BowelScreen to those aged 50 to 54 years: Statement of outcomes

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About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is an independent statutory body established to promote safety and quality in the provision of health and social care services for the benefit of the health and welfare of the public.

Reporting to the Minister for Health and engaging with relevant government Ministers and departments, HIQA has responsibility for the following:

- **Setting standards for health and social care services** — Developing person-centred standards and guidance, based on evidence and international best practice, for health and social care services in Ireland.

- **Regulating social care services** — The Chief Inspector of Social Services within HIQA is responsible for registering and inspecting residential services for older people and people with a disability, and children's special care units.

- **Regulating health services** — Regulating medical exposure to ionising radiation.

- **Monitoring services** — Monitoring the safety and quality of permanent international protection accommodation service centres, health services and children's social services against the national standards. Where necessary, HIQA investigates serious concerns about the health and welfare of people who use health services and children's social services.

- **Health technology assessment** — Evaluating the clinical and cost effectiveness of health programmes, policies, medicines, medical equipment, diagnostic and surgical techniques, health promotion and protection activities, and providing advice to enable the best use of resources and the best outcomes for people who use our health service.

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1 Introduction

Following submissions received by the National Screening Advisory Committee (NSAC) as part of the 2021 and 2022 Calls for Submissions, NSAC requested that HIQA undertake a health technology assessment (HTA) of extending BowelScreen to those aged 50 to 54 years. As outlined in the HTA protocol, multiple engagement strategies, including convening an expert advisory group (EAG) and a public and targeted consultation, were employed to ensure that all relevant and important issues from the perspectives of multiple stakeholders were taken into account during the conduct of the HTA.

Public consultation is a structured process, whereby the draft HTA report is made available, and stakeholders are invited to provide feedback within a specified timeframe. The overall aim of the public consultation was to give stakeholders not directly involved in the HTA process an opportunity to provide feedback and, based on the feedback received, to expand coverage of material requiring further clarification.

The feedback received during the public consultation and HIQA's responses to the issues raised, including any changes made to the report as a result, are summarised below.

2 Methods

The consultation process was undertaken in line with HIQA guidelines for stakeholder engagement.[1] The draft HTA report and associated draft plain language summary were published on the HIQA website for a six-week period, from 7 July to 15 August 2025.[2, 3] The consultation webpage provided access to the draft HTA report, the draft plain language summary, a press release, an infographic and information on how to participate in the consultation. To ensure wide accessibility, feedback was accepted through multiple channels, including an online feedback form hosted on the Qualtrics platform. The feedback form was also available for download from the HIQA website, and could be returned by email or post.

2.1 Consultation feedback form

The consultation feedback form comprised two free-text fields to facilitate flexibility in the responses. These related to:

1. general or specific feedback on the draft report
2. the clarity or presentation of the draft report.

A copy of the feedback form is provided in Appendix A.

2.2 Dissemination

Press materials were developed to highlight the key findings of the draft HTA. Announcements about the public consultation were also shared on social media platforms, including LinkedIn, X (formerly Twitter), Bluesky, Threads, Instagram and Facebook. Regular reminders were posted on these platforms to support continued engagement.

Targeted emails were sent to key stakeholder groups who are likely to be affected by the proposed extension of the BowelScreen programme to those aged 50 to 54 to alert them to the publication of the draft report and the public consultation. These included relevant stakeholder groups within the Health Service Executive (HSE), organisations that represent patients or the public, and professional bodies.

2.3 Synthesis

Following the closure of the consultation period, all completed submissions were exported to Excel. Submissions that were in progress at the consultation closing time were discarded. Responses submitted via email or post were transcribed and combined with the online responses. Each submission was assigned a unique identifier. Where necessary, personal information was redacted to ensure anonymity.

Submissions were considered incomplete if both of the two questions relating to the draft report contained single-word responses (for example, 'none', 'ok', 'N/A', 'unknown'), one single word and one blank response, or blank responses to both questions. These submissions were excluded from the results (Section 3). In cases where one of the two questions was skipped by the respondent, it was assumed that the respondent had no feedback in relation to that question. Submissions were categorised according to whether they were submitted by an individual or on behalf of an organisation.

The submissions were analysed thematically. A coding frame was developed based on the content of the submissions, and continuously refined throughout the analysis. Topics within each submission were coded by a single researcher. Following the initial coding of all submissions, similar or overlapping codes were combined. Related codes were then grouped into broader themes. Individual codes and the broader themes were reviewed by a second coder to ensure fidelity to the original data. The results of this analysis are presented in Section 3.2. Where relevant, the summary of results includes excerpts of verbatim responses. In some instances, grammatical and or typographical errors have been corrected to aid readability.

3 Results

3.1 Summary of submissions received

A total of 220 submissions were received in response to the public consultation, of which five were received by email. The remaining submissions were completed using the online form. No submissions were received by post. Of the submissions, 67 were incomplete (that is, both questions were left blank or contained only single-word responses) and were excluded from further analysis. An additional four submissions contained responses to the two questions that could not be coded (such as "asked by a friend" or "general or specific feedback"), leaving a total of 149 submissions.

Six submissions were completed on behalf of groups or organisations, with the remainder submitted by individuals. A total of 133 submissions expressed general support for an extension of the BowelScreen programme to those aged 50 to 54, but did not contain specific suggestions for potential amendments to the draft report. The remaining 16 submissions contained suggestions or requests for changes to the report. The results of the thematic analysis, which considered all complete submissions, are presented in Section 3.2. Section 3.3 summarises the changes made to the draft report in response to these submissions.

3.2 Key themes identified in the submissions

The findings from the thematic analysis, including the final codes and themes, along with some example excerpts from the submissions, are summarised in Appendix B. Five main themes were identified, which are described further below: support for the potential extension of the BowelScreen programme (Section 3.2.1), cost effectiveness and budget impact (Section 3.2.2), concerns regarding resources and capacity (Section 3.2.3), ethical and safety considerations (Section 3.2.4), and feedback on the clarity and presentation of the report (Section 3.2.5).

3.2.1 Support for the potential extension of the BowelScreen programme

The submissions received in response to the public and targeted consultation generally expressed support for an extension of the BowelScreen programme. These submissions outlined factors such as better clinical outcomes, personal experience, the incidence and societal impacts of colorectal cancer, and the international context, as reasons to support a potential extension of the programme.

Better clinical outcomes

Better clinical outcomes were the most frequently-cited driver of support for a BowelScreen age extension. The submissions noted that earlier detection through

screening "will help save lives" and result in higher survival rates, "much better outcomes" and "fewer deaths". Some submissions emphasised the benefits of less aggressive treatments if cancer is detected at a more treatable stage:

> *"Given that if caught early it is treatable, lowering the age for all to 50 is the most sensible option."*

> *"Extending bowel screening to 50+ is a critical step to respond to the rising incidence of colorectal cancer, and to detect this condition at its earliest stages to improve survival outcomes."*

These comments reflect a widely-held view that earlier screening could lead to improved clinical outcomes and more effective treatment pathways. As described in Chapter 3 of the HTA report, colorectal cancer typically develops slowly and may present with subtle symptoms. Cancer stage is a key determinant of treatment plans and patient survival, highlighting the importance of early detection and intervention, as almost two-thirds of screen-detected cancers in Ireland are found at early stages (stages I or II, 62%). The review of clinical effectiveness reported in Chapter 5 of the HTA report found consistent evidence that screening from age 50 reduces colorectal cancer mortality compared to no screening.

Personal experience and impact of colorectal cancer

Personal experience with colorectal cancer and related conditions, either through a family member or the respondent's own experience of the condition, was identified as a reason for supporting the extension in multiple submissions. Some submissions also highlighted an awareness of other potential risk factors:

> *"Very important to extend the screening ages – I am a late diagnosis of coeliac disease with a history of bowel cancer in my family."*

> *"Due to a family history I would like to see the screening age group reduced, as I am now 53 and have always had bowel issues since childhood."*

Individuals with a known family history of colorectal cancer (a first degree relative), or with a digestive disorder such as Crohn's disease or ulcerative colitis, may be offered screening for the condition outside of the BowelScreen programme. For individuals with symptoms of colorectal cancer, HSE recommendations advise visiting a GP, who may provide an onward referral for additional testing.[4]

The impact of a colorectal cancer diagnosis or death on a person's family and community was mentioned in a number of submissions, some of which highlighted personal experiences of loss:

> *"My wife passed away from bowel cancer in 2024 – she was stage 4 when she was diagnosed and if she had been screened there is a chance that it would have been caught early and she would still be here and my teenage children would still have a mum."*

> *"I lost my friend to CRC last year at the age of 51 years. She had two teenage children."*

> *"Every life lost has knock on impacts to a wide range of associated people (including husbands, wives, partners, parents, children, friends, siblings, cousins, colleagues etc.) plus wider society (including workplaces, the economy, social group, sports clubs etc.). It's been over 12 months since my wife passed away and I have seen the impact on all of these people and society (including a death soon afterwards, children missing school, several people undertaking therapy etc.)."*

These comments highlight the emotive and deeply personal nature of colorectal cancer and demonstrate the significant impact of the disease on individuals, their families and friends. Based on the evidence presented in Chapter 5 of the HTA report (Clinical effectiveness) and noted in Chapter 9 (Ethical, patient and social considerations), the extension of BowelScreen to those aged 50 to 54 would result in the earlier detection of cancer in this age group. Early-stage cancers can often be treated with minimally invasive procedures, leading to quicker recovery times and fewer complications, and reducing the physical and emotional burden on patients.

Increasing incidence of colorectal cancer

A variety of submissions that endorsed a potential extension to the BowelScreen programme mentioned the rising incidence of colorectal cancer, particularly among younger cohorts. Some submissions stated that cancers are increasingly diagnosed in those under the age of 60, noting a "rise in number of cases in younger people" and suggesting that the screening age range should reflect this:

> *"More and more younger people are suffering from this cancer."*

Some submissions specifically noted a rise in young-onset colorectal cancer (that is, cancer diagnosed before age 50) in endorsing a potential age extension:

> *"The rise in early-onset colon cancer is alarming, and the health system should be doing everything in its power to detect cancers as early as possible. I realise that this wouldn't cover early-onset, but it's a step in the right direction."*

The colorectal cancer incidence rate in those aged 50 to 54 has remained relatively stable in Ireland, with an average annual incidence rate of 47.3 per 100,000

between 2013 and 2021. The analysis presented in Chapter 3 (Epidemiology) indicated that the incidence rate of colorectal cancer is rising in people aged 50 or younger in Ireland, despite unchanged or decreasing incidence rates in those aged 50 and over. This increasing burden in the younger cohort raises the possibility of an increase in colorectal cancer incidence in older cohorts, most imminently for those aged 50 to 54, as the cohort matures.

Multiple submissions referred to screening practices in other countries, citing this international context as a benchmark for Ireland:

> *"[Screening] should be from the age of 50 to align with other countries."*

> *"As an Irishman who has lived in Australia, their recent change to screening options for 45 year olds has shown a successful response."*

Colorectal cancer screening practices in a number of other countries are reviewed in Chapter 2 of the HTA report (Description of technology). Across the European countries examined, the age of eligibility for screening generally ranged from 50 to 75, though some countries had a later starting age and or an earlier stopping age. Considering non-European countries, it was noted in the report that the starting age of screening was lowered from 50 to 45 in Australia as of 2024. In Europe, screening for those aged 50 to 74 years has been recommended by the Council of the European Union since 2003.[5, 6] The European Council also noted, however, that important factors must be assessed before a population-wide implementation of the recommendations is decided; these include the frequency and interval to be used in screening and national epidemiological specificities, and ethical, legal, social, medical, organisational and economic aspects.[5] Furthermore, the recommendations stated that the indicated age ranges are to be understood as maximum ranges, subject to national epidemiological evidence and prioritisation, and that smaller age ranges may be appropriate.

3.2.2 Cost effectiveness and budget impact

A number of submissions considered the costs and potential value of extending the programme when discussing their support for a BowelScreen extension, noting that the draft HTA report suggested that screening in those aged 50 to 54 was likely to be cost effective and would "save lives and will save money in the long term":

> *"The draft assessment seems to indicate that the cost-benefit analysis on screening younger people for bowel cancer is beneficial, produces better long-term medical outcomes for patients, and consequently reduces costs and pressures on the health service in terms of cancer care."*

> *"In fact, cost savings are achieved through reduced symptomatic presentations, fewer advanced cases and will lead to less costly medical intervention."*

Conversely, it was felt by some that "cost savings due to early diagnosis (via screening) [or] avoidance of cancer diagnosis has not been detailed" in the report.

The analysis presented in Chapter 7 (Resource and budget impact) suggests that the overall incremental cost of extending BowelScreen to those aged 50 to 54 years would be expected to decline over time due to earlier cancer detection, which reduces the need for more costly advanced-stage treatments. Cost savings due to early diagnosis and avoidance of cancer diagnosis that occur within the model time horizon (10 years) are incorporated into the model. The cost of treating stage I to IV colorectal cancer changes over time, as shown in Figure 7.10 in the HTA report.

It is important to note, however, that the analysis did not indicate cost savings within the first 10 years of the extension. For resources relating to cancer staging and grading (for example, diagnostic radiology and further histological examination), the model indicated that increased demand from patients identified through screening would be partially offset by the reduced demand from patients presenting in the symptomatic services. However, expanded screening increases the demand for diagnostic tests and procedures including colonoscopy, CT colonography, and examination of samples taken during colonoscopy.

Longer term predictions were outside the scope of the budget impact analysis presented in Chapter 7, which was designed to inform short-term resource and financial consequences. The model was not designed to capture long-term resource offsets. Long-term costs and health benefits associated with an age extension are captured by cost-effectiveness models, which were reviewed in Chapter 6 of the HTA report. This review found that an age extension is likely to be a cost-effective use of resources.

One submission suggested the inclusion of additional modelling scenarios, such as "a 4-year screening internal with a lower FIT cut-off", and recommended separating "capital, workforce, and consumable cost components" to clarify the drivers of cost differences and indicate which elements "require upfront vs recurrent investment". This submission is detailed in Table 3.1 below, along with a summary of the actions taken by the evaluation team in response. Suggestions relating to the clarity and presentation of information on cost effectiveness are addressed in Section 3.2.5.

Table 3.1 Examples† of suggestions for amendments to the report related to the cost effectiveness and budget impact of extending BowelScreen

Submission (excerpt)	Response and action

I welcome the proposal to extend BowelScreen eligibility to ages 50–54. This aligns with EU Council Recommendation 2022/2548 and responds to rising colorectal cancer incidence in younger adults. It represents meaningful progress and will increase early detection and survival. However, the full public health benefit will depend on optimising programme design and capacity planning… expansion of the age range alone, without adjusting the FIT threshold or screening interval, can lead to suboptimal outcomes under constrained colonoscopy capacity.
 	
Section: Methods / Modelling Approach
The modelling methods are clearly described, but the presentation would benefit from greater clarity on capacity assumptions and how these are projected into future years. For example, it is not explicit whether post-expansion colonoscopy capacity accounts for parallel demand from symptomatic referrals and surveillance, which may impact feasibility. Scenario outputs are presented, but the report would be clearer if the rationale for excluding certain interval–threshold combinations (e.g., 4-year interval with lower FIT cutoff) was explicitly stated. These combinations are relevant to optimising outcomes within capacity constraints.
 	
The draft assessment would be strengthened by including sensitivity analyses that:
• Explore alternative configurations such as a 4-year screening interval with a lower FIT cutoff (10 mg Hb/g).
• Compare these to the proposed 2-year interval at the current FIT cutoff under both current and projected capacity. Our modelling found that such approaches could:
  ○ Prevent more CRC deaths (+15–35%)
  ○ Save more QALYs (+16–35%)
  ○ Reduce costs (–23%)
  ○ Maintain or reduce colonoscopy demand.
	The scope of this HTA was to evaluate evidence for the potential extension of BowelScreen to include individuals aged 50–54. Detailed assessment of alternative FIT thresholds and screening intervals was outside the agreed scope. The terms of reference for this assessment, which were agreed between HIQA and the Chair of NSAC, on behalf of the NSAC, are outlined in Section 1.2 of the report.
	
	Changes in resource demand for symptomatic services and surveillance were incorporated into the analysis, with partial offsets from the expansion illustrated in Figure 7.7 of the HTA report.
	
	Resource constraints are discussed in Chapter 8 of the HTA report (Organisational considerations). However, no resource limitations were applied in the budget impact analysis, as the purpose of the analysis was to estimate the future capacity and budget requirements associated with the proposed intervention. A sentence was added to the budget impact chapter of the HTA report (Section 7.2) to clarify that it was not considered appropriate to place constraints on colonoscopy capacity within the budget impact model.

Submission (excerpt)	Response and action
Section: Resource Use / Budget Impact While the draft outlines budget implications for extending the programme, there is currently no transparent national reporting of cancer screening expenditure. In contrast, there is detailed data for therapeutic interventions… This imbalance in data availability limits optimal resource allocation. Given that population screening has a far lower cost/QALY (€2,000–€30,000) than many oncology drugs (€50,000–€150,000+), investment decisions should be made across the continuum of care with cost-effectiveness in mind. The budget impact section presents programme costs but does not explicitly separate capital, workforce, and consumable cost components. This limits clarity on which elements are driving cost differences and which require upfront vs recurrent investment. The absence of a comparative investment context (e.g., relative to therapeutic cancer spending) makes it harder for decision-makers to weigh prevention and early detection against treatment. Including such a comparison would enhance presentation and policy relevance.	The scope of this HTA was to assess evidence regarding the potential extension of BowelScreen to include individuals aged 50–54. As such, investment decisions elsewhere in the colorectal cancer care pathway was outside the scope. As noted in the HTA, capital costs were not included in the budget impact analysis based on input from the BowelScreen programme that most capital investment would take place in advance to support the ongoing expansion to those aged 55–74 (Section 7.4.1). A full breakdown of costs is provided in Table 7.2 of the HTA report. The budget impact analysis aims to reflect the HSE perspective with respect to resourcing the extension of an existing screening programme. Detailed breakdowns into capital, workforce, and consumables are therefore less relevant in this context. Where available, we relied on the Diagnosis-Related Group (DRG) costing system, that is, the standardised framework through which HSE-funded hospitals estimate funding requirements. However, DRG-based costs do not provide component-level detail. Furthermore, when services are outsourced (such as FIT processing), the internal breakdown of costs, such as the proportion spent on staff versus equipment, becomes less relevant than the total cost incurred by the HSE. Finally, disaggregating cost components would require a micro-costing study across the entire service pathway. New paragraphs have been added to the Discussion section of the Budget Impact Analysis chapter (Chapter 7) to reflect these points, and noting that workforce represents the largest cost driver, as indicated by a recent micro-costing study of colorectal endoscopy services in Ireland (Section 7.6.3 on Limitations).[7] Chapter 8 (Organisational considerations) also highlights significant challenges related to capacity and workforce.

Submission (excerpt)	Response and action
Section: Recommendations 1. Include additional modelling scenarios that test different FIT cutoffs and intervals under realistic capacity constraints. 2. Link age expansion to parallel capacity planning for diagnostics and surveillance. 3. Mandate transparent reporting of national cancer screening expenditure. 4. Prioritise investments by cost/QALY across prevention, early detection, and treatment.	Consideration of additional FIT cut-offs, screening intervals and other intervention strategies beyond the proposed expansion to those aged 50-54, were beyond the agreed scope of this HTA. Capacity planning for diagnosis and surveillance is an important part of this assessment. The model accounts for the effect of expanded screening on resource use, including a reduced requirement for treatment of advanced cancers and partial offsets in symptomatic services. The issue of reporting of cancer screening expenditure falls outside of the remit of the HTA. We acknowledge the challenges in accessing Irish-specific data, and recognise that improved availability would enhance transparency.

† Additional submissions are discussed narratively in the text.

Key: CRC – colorectal cancer. DRG – FIT – faecal immunochemical test. HTA – health technology assessment. NSAC – National Screening Advisory Committee. QALY – quality adjusted life year.

3.2.3 Concerns regarding resources and capacity

Several submissions identified concerns regarding the resources and capacity required to implement an extension of the BowelScreen programme, as well as potential impacts on symptomatic services. The need for dedicated funding and strategic planning to support the potential age extension was highlighted, with some submissions requesting that "additional capacity-building investment be prioritised to support expansion":

> *"While extending the programme will require significant investment and planning, the lives saved will be worth it."*

> *"Please take the necessary action to agree the reduction to 50 and also increase the resources and services to get to that age asap (as it's been 12 years since it was agreed to move to 55 and it's still not even there yet – this is costing lives)."*

Existing capacity constraints were described by several submissions, particularly in the context of feasibility of the expansion, and included concerns such as workforce shortages and logistical barriers. The potential impact of an age extension on symptomatic services, in the context of existing capacity constraints, was also noted:

> *"The health service is currently under huge pressure to provide services, and this pressure is increasing year-on-year with significant staff shortages, a rapidly growing population, and rising medical costs. Therefore, investing in cancer screening, prevention and early detection seems to be an effective use of resources."*

> *"We wish to highlight the importance of ensuring that diagnostic capacity is sufficiently supported through adequate resourcing, including workforce planning, and appropriate service support tools and process automation, as well as expansion of training provision. Without such support, there is a risk that the increased demand could inadvertently impact other patient groups by further prolonging diagnostic turnaround times within an already heavily burdened system."*

While it was acknowledged that capacity and funding were an issue, it was suggested that this should not be a barrier to implementation:

> *"The resource and service constraints are clearly an issue but a plan should be put in place to address this given the overall beneficial impact on people's lives and long term cost."*

> *"I believe all means necessary to achieve this should be explored, as the clear benefits of screening from a younger age outweigh any short-term capacity constraints. Capacity should be increased and the current constraints not used as an excuse to roll out the expanded bowel screening to men over 50."*

As highlighted in Chapter 8 (Organisational considerations), extending colorectal cancer screening, without coordinated efforts to address the constraints experienced by the services required for screening, is likely to negatively impact their ability to provide care in accordance with quality assurance standards. This could lead to longer waiting lists and worsening test result turnaround times for both BowelScreen participants and those presenting with symptoms of cancer. A phased approach to implementation, coupled with significant forward planning and investment in staffing and training, would be required to ensure sufficient resources are in place to support the implementation of an extension of screening to those aged 50 to 54. This has been noted in HIQA's Advice to NSAC.

Initiatives to relieve demand and maximise capacity

There was general support for a phased implementation of an extension of BowelScreen to those aged 50 to 54, with a number of submissions suggesting that "a phased rollout begin, with a timeline clearly communicated". Potential measures to "alleviate waiting times" and "better manage currently limited endoscopy resources" were also noted, including the "triaging of symptomatic patients using FIT" and "offering FIT tests in general practice". One submission called for a "major rethink" regarding the sourcing of endoscopists, and suggested that consideration be given to reducing "hospital commitments to free up gastroenterologists/endoscopists to perform more endoscopy lists" as a means of reducing both BowelScreen and symptomatic service waiting lists.

Section 8.10.1 of the HTA report discusses potential initiatives to relieve demand and maximise capacity, including the use of FIT as part of the symptomatic referral pathway in primary care and acute hospital gastrointestinal endoscopy services.[27, 28] This section also considers other measures to manage available resources and inform long-term capacity planning. However, as noted in the HTA report, initiatives to increase endoscopy capacity may not result in a proportionate decrease in histopathology or diagnostic radiology activity, as procedures following a positive FIT would be expected to yield a greater number of samples.

As noted in Table 3.2 below and acknowledged in Section 8.6.3 of the HTA report, colonoscopies represent only one aspect of the workload of general surgery and gastroenterology specialties. Two recent UK studies reported that the most frequently-cited activities that endoscopists would relinquish in support of increased screening activity were outpatient clinics, acute general internal medicine or surgical

on call, and general internal medicine ward cover.[14, 15] This highlights the potential opportunity cost associated with increasing the screening colonoscopy workload of existing BowelScreen endoscopists. Ensuring a supply of professionals with the required level of experience and expertise to meet quality assurance standards and key performance indicators is essential to ensuring a safe and effective service. This has been noted in HIQA's Advice to NSAC.

Capacity constraints and the scope of the assessment

A number of submissions queried the scope of the HTA, and requested that references to "resources required to lower the age of screening" be removed from the report, suggesting that "future funding decisions must be led by evidence – not constrained by current capacity":

> *"Bowel Cancer Ireland calls for the removal of constraints commentary from the final HIQA report. Bowel Cancer Ireland believes that the evidence presented in HIQA's draft HTA makes a compelling case for lowering the screening age to 50, yet this conclusion is being unnecessarily qualified by commentary on health system capacity constraints. We respectfully urge HIQA to separate implementation challenges from the evidence-based recommendation on merit."*

These submissions further suggested that "any consideration or commentary on capacity constraints as a reason to delay lowering the screening age is out of scope for this HTA."

The HTAs conducted by HIQA's HTA Directorate follow the HTA Core Model® proposed by the European Network for Health Technology Assessment (EUnetHTA),[8, 9] and commonly include organisational, social, and ethical implications as key domains. The terms of reference for this assessment, which are outlined in Section 1.2 of the HTA report and were agreed between HIQA and the Chair of the National Screening Advisory Committee, included assessing the potential resource and organisational implications of a BowelScreen age extension in Ireland.

Implementation of an extension to the BowelScreen programme to include people aged 50 to 54 requires consideration of the core principles and elements of a screening programme,[11, 12] including evidence that the complete screening programme can be implemented and that it represents an effective use of available resources.[10] The *NSAC Criteria for Appraising the Viability, Effectiveness and Appropriateness of a Screening Programme* highlight that 'adequate staffing and facilities for testing, diagnosis, treatment and programme management should be available prior to the commencement of the screening programme'.[10] As such, the organisational and resource implications of extending BowelScreen, including a

discussion of existing constraints, was a key consideration for this HTA. Significant concerns regarding capacity were also raised by the Expert Advisory Group throughout the conduct of the assessment.

A number of submissions included suggestions for amendments to the draft HTA report related to resource and capacity considerations. Table 3.2 below details some of these submissions, along with a brief summary of the actions taken by the evaluation team in response to these suggestions.

Table 3.2 Examples† of suggestions for amendments to the report related to resource and capacity considerations

Submission (excerpt)	Response and action
I felt on commencing BowelScreen the volume would be an issue and this has proven overwhelming on top of symptomatic endoscopy. Due to significant resource and manpower issues a major rethink should happen on where advanced endoscopists are going to come from as currently most of them are stuck in hospitals doing general medical call looking after everything from falls, trips, heart attacks and strokes. Most would much prefer to be doing what they are trained to do. Cardiologists/Rheumatologists and Nephrologists are now all by and large not partaking in general medical call anymore resulting in a massive burden on gastroenterologists. I think the DOH/HSE and RCPI need to relook at this wasted resource and consider reducing or removing on hospital commitments to free up gastroenterologists/endoscopists to perform more endoscopy lists. This would reduce both BowelScreen and symptomatic waiting lists.	This submission highlights an important point, namely that colonoscopies represent only one aspect of the workload of general surgery and gastroenterology specialties, with consultant gastroenterologists almost exclusively dual-trained in General Internal Medicine.[13] This is noted in Section 8.6.3 of the HTA report, which also reports findings from two recent UK studies, which indicated that the most frequently-cited activities that endoscopists would relinquish to support increased screening activity were outpatient clinics, acute general internal medicine or surgical on call, and general internal medicine ward cover.[14, 15] The *Optimise and Progression of Internal Medicine in Ireland – in Search of Excellence (OPTIMISE)* 2023 interim report indicated that internal medicine is the core business of Irish hospitals, accounting for approximately two-thirds of hospital bed days.[16] The report recommended the piloting of a model of partial or complete decoupling of internal medicine from subspecialty commitments, citing the potential for improvements in patient care and training, and a reduction in burnout.[16] Section 8.6.3 in Chapter 8 of the report (Organisational considerations) has been amended to highlight the general internal medicine workload of gastroenterologists, and to include references to the OPTIMISE interim report recommendations.
[We] would like to take this opportunity to reiterate these points outlined, in particular those regarding the broader implications on the histopathology and radiology services. We wish to highlight the importance of ensuring that diagnostic capacity is sufficiently supported through adequate resourcing, including workforce planning, and appropriate service support tools and process automation, as well as expansion of training provision. Without such support, there is a risk that the increased demand could inadvertently impact other patient groups by further prolonging diagnostic turnaround times within an already heavily burdened system. We believe these considerations remain critical and warrant continued attention as the project advances. While the presented document reflects progress, we remain mindful of the potential impacts.	The *HSE Outline Strategic Plan for Laboratory Services (2026–2035)* recommends that investment in automation of all stages of sample preparation and processing should be enhanced, to release existing scientific staff from repetitive manual tasks.[17] This has been included in Section 8.10.2 of the HTA report. Section 8.8 of the report notes that the additional demand placed on services should be carefully monitored as the planned expansion progresses. The importance of monitoring has also been included in the conclusion of Chapter 8 (Section 8.10.5), and noted in HIQA's Advice to NSAC. Section 8.10.3 has been revised to highlight the importance of ensuring that diagnostic capacity is sufficiently resourced, and to acknowledge the risk of diagnostic turnaround times being further prolonged without such support.

Submission (excerpt)	Response and action
The report correctly identifies potential workforce constraints as a factor in the decision to reduce the age of screening commencement. **Suggested Specific Amendments (Exec. Summary and Section 8):** To assess the impact on workforce demand it would be useful to show: • % increase in FIT tests overall and an assessment of additional chemical pathology workload from current • % increase in colonoscopies from current baseline • % increase in histopathology from current baseline • % increase in CT scans from current baseline Pg 28 and 29 **Exec Summary (last pars)** suggest inclusion of chemical pathology.	A new table (Table 8.3) has been included in Chapter 8 (Organisational considerations), which outlines estimates of the potential increase in the number of FIT kits, total BowelScreen colonoscopies (including index and surveillance colonoscopies and additional planned procedures), and CT colonographies that may result from an extension of the programme to those aged 50–54, compared to 2023 programme figures (based on an immediate implementation scenario). A new Table F.2 has been included in the Appendix to provide the same estimates based on a two-yearly implementation scenario. The number of CT scans or histopathology workload associated with BowelScreen is not currently reported by the programme; instead, Table 8.3 also describes the estimated potential increase in the number of participants with adenomas or cancer detected. The processing of FIT samples is automated. Table 8.12 in the report details the estimated minimum staffing requirements for a laboratory processing BowelScreen FIT samples, with an estimated 0.3 WTE consultant chemical pathologists required per laboratory. Assessing the additional workload for chemical pathology is challenging, as FIT processing is currently (as of 2025) outsourced to a single private laboratory.

† Additional submissions are discussed narratively in the text.

Key: CT – computed tomography. DoH – Department of Health. FIT – faecal immunochemical test. HSE – Health Service Executive. OPTIMISE – *Optimise and Progression of Internal Medicine in Ireland – in Search of Excellence*. RCPI – Royal College of Physicians of Ireland.

3.2.4 Ethical and safety considerations

Some submissions commented on the ethical implications of the screening age range, for example, highlighting the impact of not screening in particular age groups:

> *"The ethical considerations of not offering screening to all ages within this range is not included. Currently half the age range is covered only (59-70)."*

Another submission suggested that the programme could consider prioritising "the screening of the 50-54 age group, working upwards to 59."

The potential harms of not screening those aged 50 to 54 are considered in Section 9.3.3 of the HTA report, in the context of a discussion of the benefits and harms of screening. However, given the scope of the assessment, the ethical considerations associated with not screening those aged 55 to 74 were not included.

The implementation scenarios modelled as part of the assessment assumed that the full rollout of the planned expansion to those aged 55 to 74 would be completed prior to a potential extension to those aged 50 to 54. Alternative implementation options, such as prioritising the expansion of the age range downwards and delaying expansion to those aged over 70 until after the extension to those aged 50 to 54 has been completed, are acknowledged in the HTA report, but were not explicitly modelled.

Uptake of colorectal cancer screening

A number of submissions referenced the uptake of the BowelScreen programme, which to date has not reached the minimum target uptake rate of 50%. Submissions included suggestions for how to maximise engagement through avenues such as communication strategies and alternative sample collection methods. The importance of public awareness campaigns and outreach programmes "aligned with rollout to maximise uptake and equity" were highlighted, with some submissions citing the Marie Keating Foundation's '#NoRegrets' campaign as a model for promoting screening.

Colorectal cancer screening uptake rates are a recognised issue, and are discussed throughout the HTA report. As noted in Chapter 8 (Organisational considerations), BowelScreen has trialled a number of initiatives to increase uptake rates, including direct mail out of FIT kits and incorporation of behavioural science insights into screening invitation letters.[23, 24] Advertising campaigns have also showed success in increasing uptake, with a social media campaign, which highlighted the expansion of BowelScreen to those aged 59 in 2023, resulting in a 279% increase in registrations.[25]

Concerns regarding uptake of screening among "under-screened groups" were also highlighted, with one submission suggesting the use of "targeted community engagement" and "mobile screening units" as potential measures to improve uptake. This submission also recommended "public reporting of uptake disaggregated by socio-demographic factors". Extending screening to those aged 50 to 54 may serve to increase disparities if those who are at higher risk of colorectal cancer are less likely to participate. As such, an extension of the programme should incorporate efforts to enhance equity and uptake.

Section 9.5.2 of the HTA report outlines the impact of a variety of factors on screening uptake, including age, gender, socioeconomic status, geographic location, ethnicity, and the presence of other conditions. The report also acknowledges the ongoing efforts by BowelScreen and the National Screening Service to engage with underserved populations to increase uptake rates and mitigate barriers to participation. As noted in Table 3.3 below, disaggregated uptake rates for BowelScreen by age and sex are presented in Chapter 2 (Section 2.4.3) of the HTA report. As of 2025, BowelScreen disaggregated uptake by other sociodemographic factors is not reported.

A number of submissions proposed the diversification of testing options, including the use of capsule colonoscopy and alternative sample collection measures:

> *"Capsule colonoscopies should also be considered for patients who are unable to have a colonoscopy - I had an attempt scope myself which couldn't be passed by the doctor. I was able to get the capsule instead. This should be part of screening."*

> *"Could consider adopting wipes/swab rather than sticks as a stool collection device as this might increase uptake."*

Lowering the screening age to below 50

Some submissions suggested that screening for colorectal cancer should start at a younger age than the proposed extension of BowelScreen to those aged 50 to 54, including proposals for lowering the age further following an initial expansion, as well as more substantial changes to screen younger age groups:

> *"Early diagnostics is needed to save lives. While 50 to 54 is an improvement I would like to see it moved to 30s or 40s."*

> *"Having considered the proposal to extend bowel screening to those aged 50–54, I would see this as a positive development. I do however feel that greater ambition is warranted, and that offering screening to those aged 45+ would be helpful."*

Screening is recommended by the Council of the European Union for those aged 50 to 74 years.[5, 6] Internationally, some guidelines include 'conditional' or 'grade B' recommendations for screening in those aged 45 to 49, based on very low-quality evidence or moderate certainty that screening in this age group has a moderate net benefit.[27-29] While colorectal cancer screening guidelines and practices in other countries were reviewed as part of the assessment (see Section 2.5 and Section 2.6 of the HTA report), assessing the benefits and harms of screening in those younger than 50 was outside of the scope of the HTA.

Harms of screening

A submission from an advocacy group suggested that "negative experiences during colonoscopy can have a ripple effect of putting people off engaging with the screening programme", and that participants' awareness "of their rights under HSE policy and the Patient Safety Act is critical to building a culture of transparency, learning, and accountability within the screening pathway." This submission also highlighted the need for person-centred design, calling for the lived experience to be embedded "in the co-design and implementation of screening policies."

Section 9.5.2 of the HTA report discusses the uptake of colorectal cancer screening in Ireland, outlining that negative cancer and screening-related beliefs and or emotions have been found to be negatively associated with participation.[26] Section 9.4.1 outlines the importance of autonomy when making the decision to participate in screening. It further discusses the need to inform those eligible for screening of the potential harms of participating in the programme (such as overdiagnosis and overtreatment). The need to balance the promotion of the programme and measures to increase uptake with respect for individual preferences, and the need to ensure that individuals can make a fully informed choice before agreeing to participate, is also highlighted.

Other submissions highlighted the potential harms of computed tomography (CT) colonography and safety of colonoscopy:

> *"The relatively low but not non-existent risk of cancer induction from low levels of ionising radiation used in diagnostic imaging… deserves a stand alone section."*
>
> *"We strongly emphasise the need for this expansion to be implemented with a parallel focus on the quality and safety of diagnostic follow-up care—particularly colonoscopy."*

Table 3.3 below details some of these submissions, along with a brief summary of the actions taken by the evaluation team in response to these suggestions.

Table 3.3 Examples† of suggestions for amendments related to ethical and safety considerations

Submission (excerpt)	Response and action
Section: Equity Considerations The draft could more explicitly address strategies to improve uptake among under-screened groups. Current BowelScreen uptake is 46.4% overall and as low as 7.5% for men aged 65–69. Expansion to younger ages will only deliver full benefit if participation is increased and equitable. Suggested measures: - Targeted community engagement (e.g., rural, low-income, minority groups) - Mobile screening units - Public reporting of uptake disaggregated by socio-demographic factors The equity section identifies lower participation among certain demographic groups but could more clearly present disaggregated uptake data (e.g., by age, gender, deprivation quintile, rurality). This would better illustrate the scale of inequities and target groups for intervention. **Section: Recommendations** Embed equity strategies into programme expansion.	Extending screening to those aged 50–54 may serve to increase disparities, if those who are at higher risk of colorectal cancer are less likely to participate. As such, an extension of the programme should incorporate efforts to enhance equity and uptake. This has been incorporated into HIQA's Advice to NSAC. Disaggregated uptake data for BowelScreen by age and sex is presented in Chapter 2 of the HTA report (Section 2.4.3). As of 2025, the programme does not report uptake rates by deprivation level or location. The *National Screening Service Improving equity in screening: A strategic framework 2023–2027* acknowledges limitations in the available data, highlighting the agreement of a minimum set of equity stratifiers as an area of focus. Section 9.5.1 (Distributive justice) in Chapter 9 (Ethical, patient and social considerations), which outlines the existing and potential additional disparities that may arise as a result of the expansion of the programme, has been expanded to acknowledge the gaps in the measurement of equity in screening.
The Council of EU has recommended screening for age 50-74 23 years ago. The ethical considerations of not offering screening to all ages within this range is not included.	The benefit-harm balance of colorectal cancer screening in those aged 50 to 54 is considered in Section 9.3.3, which also notes the potential harms of not screening this age group. Specific reference is made to the non-realisation of benefits such as earlier detection, treatment, and improved outcomes.
Public awareness campaigns are aligned with rollout to maximise uptake and equity.	Public awareness campaigns have showed success in increasing uptake, with a social media campaign, which highlighted the expansion of BowelScreen to those aged 59 in 2023, resulting in a 279% increase in registrations.[25] This is discussed in Section 8.9.2 of the HTA report. A phased approach to implementation and efforts to enhance equity and uptake have been included in HIQA's Advice to NSAC.

Submission (excerpt)	Response and action
We also wish to highlight the importance of embedding the lived experience of patients in the co-design and implementation of screening policies. Including service users in governance and evaluation structures for BowelScreen would help ensure that the programme is not only clinically effective and cost-efficient, but also truly person-centred. Furthermore, we hope that there will be prominent visibility of the Patient Advocacy Service across the programme. [This] service provides empowerment advocacy to help people understand their rights and engage fully with screening, and [offers] support in the aftermath of patient safety incidents that may occur. Ensuring patients are aware of their rights under HSE policy and the Patient Safety Act is critical to building a culture of transparency, learning, and accountability within the screening pathway.	Service user perspectives are incorporated through the National Screening Service Public and Patient Partnership (PPP) Panel, and patient-reported experience measures are used to inform service improvements.[34, 35] The BowelScreen Patient Reported Experience Measures (PREMs) collect feedback on participants' experiences of colorectal cancer screening. The 2023 PREMs report[34] is cited in both Chapter 5 (Review of clinical effectiveness) and Chapter 9 (Ethical, patient, and social considerations) of the HTA report. Section 9.4.1 has been updated to include a reference to the Patient Safety Act, as well as to highlight the potential for collaboration between the BowelScreen programme and the Patient Advocacy Service.
Section 5.5.5 harm of screening. The relatively low but not non-existent risk of cancer induction from low levels of ionising radiation used in diagnostic imaging while mentioned earlier, deserves a stand alone section here. Overall incidence of cancer induction becomes more of an issue in younger age groups and increasing use and overreliance on medical imaging particularly CT in modern practice means population-wide radiation exposure must be considered, particularly in otherwise healthy screening population. This has been highlighted in a recent JAMA article (JAMA Intern Med. doi:10.1001/jamainternmed.2025.0505). Additional risks that should be highlighted with CT is the high incidence of incidental findings which often necessitate further workup, and the associated psychological, potential physical (if repeat CTs and associated radiation exposures are required) and possible financial stress this will cause for patients, not to mention the knock on effects on imaging and other medical services. Interpretation error rates, while low, are another potential source of morbidity, as well as potential complications relating to the procedure including allergic or reactions to IV buscopan routinely administered pre CTC, or contrast reactions if IV contrast is deemed necessary to further evaluate a finding or on follow up.	The risks of ionising radiation exposure during CT colonography scans were also noted by the Expert Advisory Group. As highlighted by this submission, a modelling study was published in *JAMA Internal Medicine* in 2025, which estimates lifetime cancer risks due to ionising radiation exposure from CT scans. This study concluded that projected cancer risks due to ionising radiation exposure increased at younger ages, with the highest number of projected cancer cases in those aged 50 to 59, with highest overall CT utilisation. The BowelScreen quality assurance standards outline the minimum standards required for screening CTC, including radiation dose. Sections 5.4.6 and 5.6.5 of the HTA report have been updated to include sub-sections on harms of CT colonography. Extracolonic findings are relatively common with screening CT colonography and may require follow up with additional imaging or biopsies and further specialist referrals. This has been noted in Section 8.6.5 of the HTA report.

Submission (excerpt)	Response and action
We strongly emphasise the need for this expansion to be implemented with a parallel focus on the quality and safety of diagnostic follow-up care—particularly colonoscopy… including issues related to inadequate sedation and the psychological impact of distressing experiences. Negative experiences during colonoscopy can have a ripple effect of putting people off engaging with the screening programme.	It is essential that colonoscopy is performed to a high standard and that it is both safe and comfortable.[30] The BowelScreen quality assurance standards note the importance of minimising harm to the screening population and optimising participant experience.[31] Factors contributing to the level of discomfort or pain experienced during colonoscopy include administration of adequate sedation, as well as participant, operator and procedural factors. The BowelScreen quality assurance standards state that screening colonoscopy units should conduct rolling audits of sedation practice, comfort scores and the use of reversal agents in line with the National GI Endoscopy Quality Improvement Programme. Section 5.5 of the HTA report has been expanded to include reference to discomfort, psychological distress and subsequent symptoms after colonoscopy. Table 9.2 in Chapter 9 (Ethical, patient and social considerations) outlines BowelScreen quality assurance standards for colonoscopy harms, and has been updated to include comfort scores.

† Additional submissions are discussed narratively in the text.

Key: CRC – colorectal cancer. CT – computed tomography. CTC – computed tomography colonography. GI – gastrointestinal. IV – intravenous. JAMA – Journal of the American Medical Association. NSAC – National Screening Advisory Committee. PPP – patient and public partnership. PREMs – patient reported outcome measures.

3.2.5 Feedback on the clarity and presentation of the report

Accessibility and presentation

A number of responses provided feedback on the report structure in general, with a total of 18 submissions commenting on the length, readability and accessibility of the report, and offering suggestions to improve particular aspects. While some submissions noted that "the document is… too long to expect a member of the general public to provide feedback", others suggested that the report was "very clear and understandable, especially to a layperson."

Submissions noted that the draft report was "well structured" and "clearly written", and "commended" the inclusion of the plain language summary":

> *"We commend HIQA for producing a comprehensive, well-prepared report, and especially for providing a Plain English summary that made the findings far more accessible."*

While the plain language summary was appreciated, some responses commented on the accessibility of the overall report:

> *"The size and complexity of the main document can make it difficult for readers to navigate and fully absorb all its content."*

> *"It is very word heavy for the ordinary person, I understand it has to be fully informative but there is a lot of information on here that excludes people with dyslexia or visual impairment etc."*

Some submissions provided suggestions for the executive summary and key points, such as "highlighting key statistics (e.g., number of cases, deaths, and projected lives saved) more prominently". As noted in Table 3.4below, the final technical HTA report will be published in full to support transparency and provide interested parties with full access to the information that informed HIQA's Advice to the National Screening Advisory Committee. A Plain Language Summary is included in the HTA report, and will also be published as a separate document in order to improve accessibility.

An abbreviated 'key findings' section has been included in the final HTA report, while an infographic summarising the key findings will also accompany the final report. Table 3.4 provides additional detail on some of the submissions that included suggested amendments that were related to the accessibility and presentation of the draft report.

Table 3.4 Examples† of suggestions for amendments related accessibility, clarity and presentation of the report

Submission text	Response and action
Typo on page 267 paragraph 3 noted: "Toutlines".	This should read 'Table 8.7 outlines…' This has been amended in the report.
The report is technically detailed but dense. A summary table of key findings, trade-offs, and recommendations at the start of the executive summary would improve accessibility for non-technical readers. Acronyms (e.g., FIT, QALY) are defined, but repeated reuse of technical abbreviations without plain-language refreshers may reduce accessibility for a wider stakeholder audience.	The full technical report will be published to support transparency and provide interested parties with full access to the information that informed HIQA's Advice to NSAC. A Plain Language Summary is included in the report, and will also be published as a separate document to improve accessibility. An abbreviated 'key findings' section has been included in the final report. An infographic summarising the key findings will accompany the final report.
To improve accessibility, I would suggest: Adding a brief plain-language summary at the start, so members of the public can easily understand the key findings and implications. Highlighting key statistics (e.g., number of cases, deaths, and projected lives saved) more prominently in the executive summary. Including a simple visual timeline of potential rollout and resource requirements to help communicate next steps. These adjustments would make the report clearer for both policymakers and the general public.	
Highlight key stats (cases, deaths, lives saved) more clearly in the executive summary.	
Regarding the report, the full document is nearly 500 pages long and contains a significant amount of detailed information. We believe this represents a substantial volume of material for members of the public to review in full, particularly within the consultation timeframe. While the report is comprehensive and well-prepared, which we commend, the sheer length and level of detail can make it difficult for readers to navigate and absorb all the content effectively.	

† Additional submissions are discussed narratively in the text.
Key: FIT – faecal immunochemical test. NSAC – National Screening Advisory Committee. QALY – quality adjusted life year.

Suggestions for clarifications

One submission suggested that "the earliest age for which screening can commence" should be clarified. As noted in Section 3.2.4 above, some international guidelines include 'conditional' or 'grade B' recommendations for screening in those aged 45 to 49, based on very low-quality evidence or moderate certainty that screening in this age group has a moderate net benefit.[27-29] While colorectal cancer screening guidelines and practices in other countries were reviewed as part of the assessment (see Section 2.5 and Section 2.6 of the report), assessing the benefits and harms of screening in those younger than 50 was outside of the scope of this HTA.

Regarding statements throughout the report on the cost effectiveness of colorectal cancer screening in those aged 50 to 54, one submission suggested an amendment to acknowledge that screening in this age group would be considered an efficient use of healthcare resources only "if more cost effective healthcare is not displaced". An assessment of the cost effectiveness of an intervention is based on the assumption that the resources required to implement an intervention arise from additional resources allocated to the health system, reallocation from cost savings, or discontinuation of low-value care. If implementing an age extension for BowelScreen displaces more cost-effective care (such as the endoscopy capacity required for a cohort with a greater capacity to benefit), an age extension of the programme should not be considered cost effective. A paragraph outlining the relationship between reallocation of resources and cost effectiveness has been included in Section 6.5.2 in Chapter 6 of the HTA report (Review of cost effectiveness), and statements on the cost effectiveness of screening those aged 50 to 54 have been amended in the report.

One submission suggested that "the link between model outputs and final policy recommendations is not always transparent", recommending the use of a "'decision logic' diagram [to] help readers follow how results translate into the preferred policy." HIQA's advice to the National Screening Advisory Committee serves to summarise the findings of the various evidence syntheses performed across the domains of the HTA. The National Screening Advisory Committee will consider this advice in formulating its recommendation to the Minister for Health, with whom the final decision rests.

3.3 Changes to the report arising from the consultation process

The following changes were made to the HTA report in response to comments and feedback received through the consultation process. This is not an exhaustive list of changes made to the report post-public consultation. This section does not outline changes to the report that were made for other reasons, for example, in response to feedback received from the Expert Advisory Group, or updated information identified in the literature. While not all submissions required changes to the report, all submissions were carefully considered by the evaluation team in the preparation of HIQA's Advice to NSAC.

- Executive summary
    - An explanation was added outlining that an age extension may only be considered cost effective provided that implementation does not displace more cost-effective healthcare.
- Chapter 5 (Clinical effectiveness)

- A new section on harms of CT colonography was added to Section 5.4.6.
- Additional detail was added under Section 5.5 on 'Harms reported by the BowelScreen programme', discussing the patient experience and quality measures relating to colonoscopy.
- A paragraph on harms of CT colonography was included in Section 5.6.5.

- Chapter 6 (Cost effectiveness)
  - A paragraph outlining the relationship between reallocation of resources and cost effectiveness was included in Section 6.5.2.
- Chapter 7 (Resource and budget impact)
  - A sentence was added to Section 7.2 to clarify that it was not considered appropriate to place constraints on colonoscopy capacity within the budget impact model.
  - The Discussion section (Section 7.6) was updated to highlight that costs associated with the workforce are likely to be the main cost driver.
- Chapter 8 (Organisational considerations)
  - A new Table 8.3 was included to outline estimates of the potential increase in the number of FIT kits, colonoscopies, CT colonographies, and participants with adenomas or cancer detected (based on an immediate implementation scenario) compared to 2023 programme figures. A new Table F.2 was included in the Appendix to provide the same estimates based on a two-yearly implementation scenario.
  - A typographical error in Section 8.4.3 was corrected.
  - Section 8.6.3 was restructured and expanded to highlight the general internal medicine workload of gastroenterologists, and to include references to the *Optimise and Progression of Internal Medicine in Ireland – in Search of Excellence* (OPTIMISE) project interim report recommendations.
  - A sentence outlining the potential need for follow up of extracolonic findings associated with CT colonography was added to Section 8.6.5.
  - A sentence on the *HSE Outline Strategic Plan for Laboratory Services* recommendation for investment in automation was included in Section 8.10.2.

- The importance of monitoring the additional demand placed on services, as the planned expansion of the programme progresses, was included in Section 8.10.5.

- Chapter 9 (Ethical, patient, and social considerations)
  - Sections 9.3.1, 9.5.1 and 9.7 were updated to highlight that the age extension should not be considered cost effective if implementation requires the displacement of more cost-effective care.
  - Quality assurance standards relating to comfort scores for colonoscopy were included in Table 9.2.
  - Section 9.5.1 was expanded to acknowledge the gaps in the measurement of equity in screening.

3.4 Post-consultation outcomes

Following revision of the HTA report to take into account the feedback received, the Key Findings and Advice to NSAC were developed, and are presented in the final version of the HTA. Following approval by the Board of HIQA, the revised HTA report, including HIQA's advice to NSAC and this statement of outcomes report, were submitted to NSAC for consideration in November 2025.

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Appendix A: Copy of the consultation feedback form

Health Technology Assessment of extending BowelScreen to those aged 50 to 54 years

Public Consultation feedback form

The Health Information and Quality Authority (HIQA) is holding a six-week public consultation to give people an opportunity to provide feedback on the health technology assessment of extending BowelScreen to those aged 50 to 54.

Your views are important to us. HIQA will carefully assess all feedback received and, where appropriate, incorporate it into the report.

The final assessment and a statement of outcomes report (a summary of the consultation responses) will be published on HIQA's website once the HTA has been completed.

The closing date for the public consultation is 5 pm on Friday, 15 August 2025.

How to provide feedback:

- If you are commenting in a personal capacity, there is no need to provide your name or any other personal information.
- If you are commenting on behalf of an organisation, please combine all feedback from your organisation into one submission form. We will request a name and contact number for a designated representative from your organisation in case we need to clarify your feedback.
- If your feedback contains any commercially sensitive or confidential information, please highlight this at the time of submission, so it can be excluded from the summary of feedback that will be published by HIQA.
- Please spell out any abbreviations that you use.

You can **email** the completed form to consultation@hiqa.ie

OR

Print the consultation feedback form and **post** the completed form to:

Health Information and Quality Authority
Public consultation on HTA of extending BowelScreen to those aged 50 to 54
Dublin Regional Office
George's Court,
George's Lane,
Smithfield,
Dublin 7,
D07 E98Y

Data protection and Freedom of Information

HIQA will only collect personal information, such as the names of individuals who provided feedback or any other personal details during this consultation, for the purposes of seeking clarification on your feedback, if necessary. No personal information will be included in the stakeholder consultation document that will be published by HIQA.

Any response you provide will be held securely and anonymised. Information provided in your response, for example, an anecdote or statement about an experience, may be included in the statement of outcomes that will be published by HIQA at the end of the HTA process. However, information will be provided in a manner which protects the privacy of respondents. All personal information will be deleted once no longer needed, in line with HIQA's record retention policy.

For further information on how HIQA uses personal information, please see our Privacy Notice available here. If you have any concerns regarding your personal information, please contact HIQA's Data Protection Officer at dpo@hiqa.ie.

Please note that HIQA is subject to the Freedom of Information (FOI) Act and the statutory Code of Practice in relation to FOI. We cannot give you an assurance that confidentiality can be maintained in all circumstances due to the requirements of the FOI Act.

☐ **I agree to take part in the public consultation**

1. About you

1.1 Are you providing feedback as:

☐ an individual

☐ on behalf of an organisation

1.2 If answer is 'on behalf of an organisation', please give the name of the organisation:

If applicable, for clarification purposes, please provide your name, your role in the above organisation and your contact details:

2. Your feedback on the draft health technology assessment

2.1 Please provide any general or specific feedback you have on the draft assessment. Where applicable, please specify the section to which you are referring.

2.2 Please outline any issues with the clarity or presentation of the draft report. In your response, where applicable, please specify the section to which you are referring.

Thank you for taking the time to share your feedback with us

Please ensure that you return your completed form to us either by email or post, to reach us by Friday, **15 August 2025**.

If you have any questions, please contact the evaluation team at consultation@hiqa.ie or by phone at (021) 240 9300.

Appendix B: Codes and themes identified through thematic analysis

Table B.1 Summary of final codes and themes identified through thematic analysis of submissions

Code	Description	Number of submissions	Theme
Support for extension	Comments expressing general support for lowering the screening age.	149	Support for the potential extension of the BowelScreen programme.
Better outcomes	Any mention of improved outcomes (reduced mortality, better treatment options etc.).	58	
Personal experience and family history	Any mention of personal experience of CRC, or family history of CRC.	25	
Incidence and mortality of CRC	Any mention of the incidence of colorectal cancer, or CRC related death.	32	
Impact of CRC diagnosis and or death on family/society	Any mention of the impact of a colorectal cancer diagnosis or death on an individual, their family or society.	16	
International context	Any mention of colorectal cancer screening age ranges in other countries.	12	
Young-onset CRC	Any mention of colorectal cancer in someone under the age of 50 years.	9	
Risk factors and other digestive conditions	Any mention of risk factors for colorectal cancer, including other digestive conditions.	9	
Cost effectiveness and budget impact	Any mention of the value for money of colorectal cancer screening.	20	Cost effectiveness and budget impact.
Resource planning and investment	Any mention of funding, staffing, and infrastructure to support expansion.	22	Concerns regarding resources and capacity.
System capacity, constraints, and symptomatic services	Any mention of capacity constraints such as staffing, technology, and logistics, and the potential impact on symptomatic services.	22	
Lowering the screening age to below 50 years	Any mention of screening below 50 years.	16	Ethical, patient and social, and safety considerations.
Uptake	Any mention of programme participation and or uptake.	5	

Code	Description	Number of submissions	Theme
Service user involvement	Any mention of the incorporation of patient experience into programme planning.	1	
Capsule endoscopy and other screening tests	Any mention of alternative CRC screening methods (that is, other than FIT, colonoscopy, and CT colonography).	2	
Safety of colonoscopy	Any mention of the safety of colonoscopy.	1	
Harms of CT colonography	Any mention of harms of CT colonography.	1	
Comment on presentation – negative/neutral	Concerns about the length, layout, clarity or presentation of the report.	1	Clarity and presentation of the report.
Comment on presentation – positive	Any positive feedback on the layout, clarity, presentation or content of the report.	17	
Suggestion for clarity	Any mention of suggestions or advice on improving the readability of the report and or interpretation of the results.	13	

Key: CRC – colorectal cancer. FIT – faecal immunochemical test. CT – computed tomography.

Published by the Health Information and Quality Authority (HIQA).

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