NHS
Cancer Screening Programmes

NHS BOWEL CANCER SCREENING PROGRAMME

ACCREDITATION OF SCREENING COLONOSCOPISTS

BCSP Implementation Guide No 3

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1. INTRODUCTION

The NHS Bowel Cancer Screening Programme (NHS BCSP) is being implemented over a 3 year period and the aim is to recruit up to 200 expert colonoscopists to carry out the 30,000 extra colonoscopies required to fulfil the programme. Given the known variability in colonoscopic skills, strict criteria for the accreditation of screening endoscopists have been developed to minimise the risks of complications and inaccurate and incomplete examinations.

There are several advantages of this accreditation process, both to the unit and the individual endoscopists involved. Accreditation is an essential part of the preparations for the implementation of screening locally. It also provides an opportunity to demonstrate high level colonoscopic skills, and to improve the local endoscopy service. In addition it will help those clinicians who wish to teach colonoscopy, locally or on courses. The accreditation process, which leads to the NHS Bowel Cancer Screening Programme certificate is shown in Figure 1.

2. ACCREDITATION PANEL

An Accreditation Panel will advise the NHS BCSP on the process of assessment and accreditation and assure the quality of the process. Terms of reference for the Panel are given in Appendix 1.

3. SELECTION AND TRAINING OF ASSESSORS

Details of the selection criteria and training requirements for assessors are given in Appendix 2. Briefing and instructions for assessors are given in Appendix 3.

4. APPLICATIONS FOR SCREENING ACCREDITATION

Applications for screening accreditation will be invited based on the following criteria. An example application form is shown in Appendix 4.

1. Applicants must be attached to a screening centre which has received approval to commence bowel cancer screening on an agreed date.

2. Preference will be given to applicants carrying out more than 200 examinations per annum but a threshold level of 150 examinations in the 12 months prior to accreditation will be necessary. Documentation must be supplied, but it will be expected that a proportion of these examinations will be done by SpRs and others under the supervision of the applicant, and in private practice. Applicants must also have a minimum lifetime colonoscopy experience of 1000 examinations.

3. Applicants should have a documented unadjusted completion rate on an intention to treat basis of 90% or greater over the preceding year. This will include patients with bowel resection, but patients with incomplete examinations due to obstructing lesions or faecal obstruction will count as failures. Documentation on the complication rate of this series (which should include vasovagal attacks, bleeding problems, unplanned admissions and use

of reversal agents) will also be required. The audit should be verified and signed off by the Endoscopy Unit Sister or Manager and a consultant colleague/ clinical director/ medical director, both of whom should have been offered inspection of the raw data.

4. Applications will be accepted on the understanding that, if successful, the applicant will commence screening colonoscopies within six months of accreditation.

5. Applicants should be aware that their application confirms their intention to undertake 150 or more screening colonoscopies, and to continue to submit quality monitoring data on at least an annual basis.

6. Applicants must be fully registered with the GMC or appropriate professional body and be in good standing.

5. ACCREDITATION ASSESSMENT PROCESS

5.1 Acceptance of applications

Applications will be screened by the Accreditation Panel Secretary, and those that meet the six criteria outlined above will be invited for further assessment at one of four centres. Any applications that fall outside the criteria will be referred back to the candidate. In ambiguous cases, the application will be referred to the panel for review.

5.2 Written assessment

The assessment include a one hour multiple choice questionnaire (MCQ), of 30 questions based largely on lesion recognition and management. A list of topics is included in Appendix 5. Sources of reading for candidates to prepare for the written assessment are given in the Bibliography.

5.3 Direct observation of procedural skills

The written assessment will be followed by a direct observation of procedural skills (DOPS) examination over two consecutive cases. The DOPS will be supervised by a minimum of two trained assessors, who will both be present in the endoscopy room. The candidate will be offered the facility of viewing the magnetic imager but are under no obligation whatsoever to do so. They should be advised that, if they are not used to viewing the image, it may be counterproductive. The assessors may still wish to view the images to aid analysis and feedback. The candidate will be assessed taking consent, giving sedation, inserting to the caecum, examining during withdrawal, applying any appropriate therapy, and discussing results and management with the patient. Any information leaflets that the patient has received should be made available to the candidate. The pre–endoscopy patient documentation (endoscopy checklist) containing past medical and medication history and allergies should be made available to the candidate.

The DOPS assessment will be conducted according to defined criteria, and the assessors will make a decision as to whether the candidate either:

- meets the criteria

or

- does not yet meet the criteria / needs further development.

To guide assessors, the DOPS assessment form is divided into four domains. These four domains are Assessment, Consent & Communication; Safety & Sedation; Endoscopic Skills; Diagnostic & Therapeutic Ability. There is an outline of each domain on the assessment form shown at Appendix 6. In each domain, there are sub-domains for discrete areas of practice. Grade descriptors outlining the levels of achievement representing each of the four (4,3,2,1) levels are given in Appendix 7. Assessors will grade candidates against the criteria, and then use their gradings to inform their final decision that the candidate currently meets or does not yet meet the criteria.

The DOPS assessment lasts 45 minutes, including consent which should take no more than 5 minutes. The caecum should have been reached after 30 minutes – if not, an assessor may take over. At 45 minutes the assessment ends whatever the circumstances, and an assessor will complete the case. If there is an unexpected burden of pathology to deal with, but the candidate is proceeding satisfactorily, the assessment may be extended at the assessors' discretion.

Because colonoscopies vary considerably in difficulty and are unpredictable, completing all cases to the caecum is not required. Terminal ileal intubation is not a pre-requisite for successful completion. Candidates may be allowed to miss small(<5mm) polyps and still meet the criteria for screening. Candidates should however mention any lesions that they have seen but are leaving alone. The degree of difficulty of each case will be recorded and taken into account by the assessors

In difficult cases, the candidate may ask for assistance and use that particular procedure as a learning experience. This would not automatically result in a candidate "not yet meeting the criteria" (the assessors may also not be able to fully complete the procedure). Rarely, the assessors may suspend the assessment if in their joint view the assessment is endangering the patient. This automatically means that the candidate does not yet meet the criteria. This policy will be reinforced to candidates prior to the assessment. In the unlikely event of a case where the two assessors have serious concerns about the competence of the colonoscopist, the assessors will communicate these concerns to the candidate. The assessors may feel that they are professionally obliged to inform the candidate's Trust medical director in confidence immediately. Notwithstanding any immediate action taken, a full report will be made to the Accreditation Panel, who will confidentially forward any recommendations for further training to the candidate's Trust medical director.

5.4 Feedback to candidates

At the end of the assessment the assessors will complete the DOPS assessment form (Appendix 6). They will also record written feedback on specific areas of good practice and on areas for further training and development. The DOPS feedback form is at Appendix 8. The assessment results and feedback will be communicated to the candidates at the time in private, taking a maximum of 10 minutes. The results will be forwarded to the Accreditation Panel for formal ratification. The usual outcome will be that the assessors recommend to the Panel that the candidates be either accredited, or, occasionally, that there is a period of further endoscopic professional development and that the candidate has a further assessment. This will be with two different assessors.

5.5 Accreditation Panel

Once all elements of the assessment are complete, the results will be assembled by the Panel Secretary, and the panel convened. This may be in conference in person, or by video, telephone, or electronic link. The panel will formally review the three elements of the

accreditation process. If all the criteria are met the Panel will recommend to the NHS BCSP that the candidate be formally accredited. The national office of the NHS BCSP will inform the candidate by letter and issue a certificate of accreditation. If the criteria are not fully met, the Panel will make appropriate recommendations to the BCSP with respect to feedback and further developmental suggestions and training needs. Candidates may dispute the process of assessment, but not the judgement of the Panel.

6. CRITERIA FOR CONTINUED ACCREDITATION

The status of accredited screening colonoscopists will be reviewed by the Accreditation Panel on an annual basis. Accreditation will be renewed if the following criteria are met:

- to undertake a minimum of 150 screening colonoscopies per annum
- to submit quality monitoring data on an annual basis, and to continue to meet the application criteria
- to maintain an acceptable level of complications over a prolonged period, below the national average as defined in recent published series (Bowles et al, 2004).

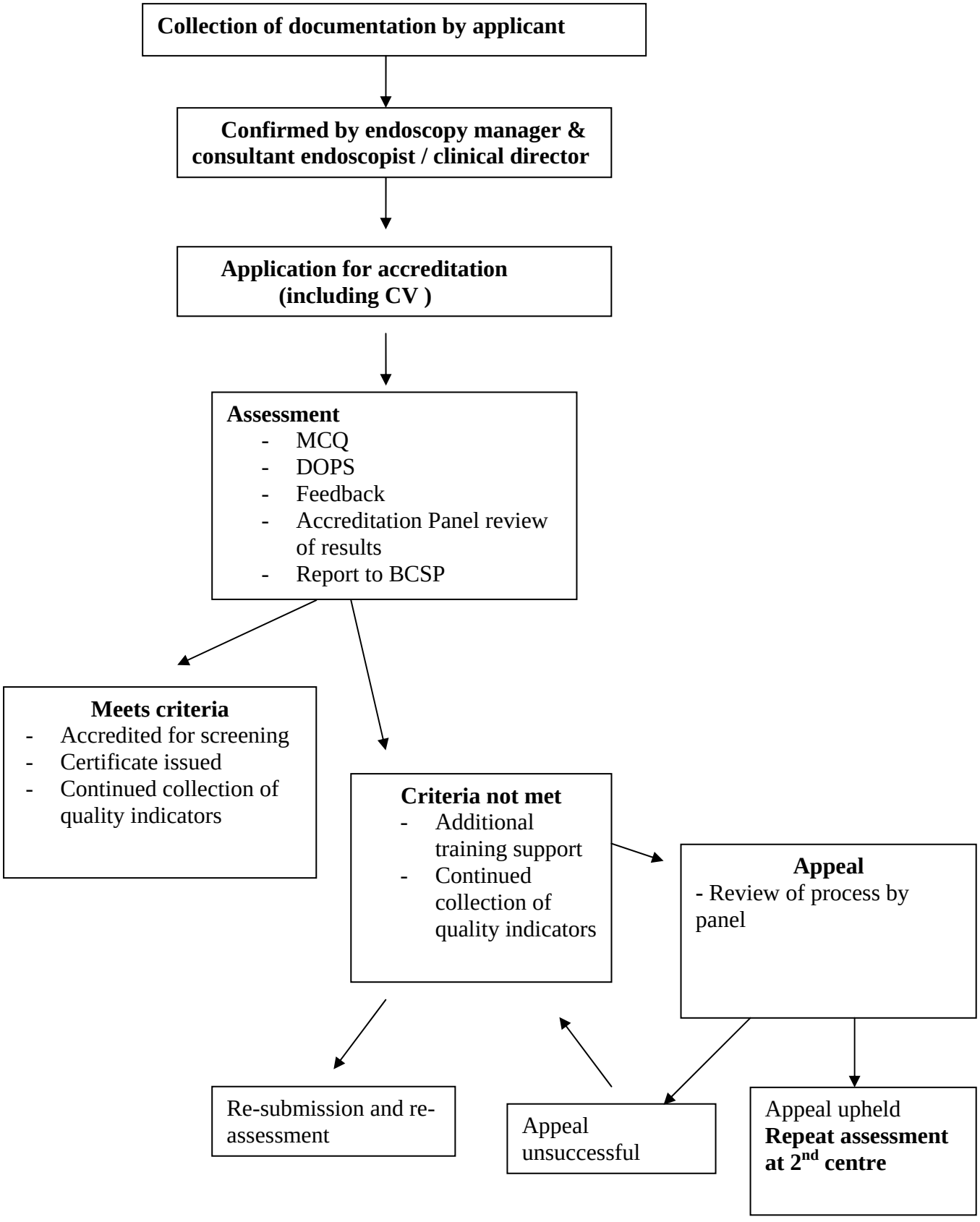
Details of actions which may be taken if the criteria are not met are given in Appendix 9.

7. ASSESSMENT CENTRES AND ENQUIRIES

Assessment centres are located at St Mark's Hospital (London), St George's Hospital (London), New Cross Hospital (Wolverhampton), Northern General Hospital (Sheffield) and Torbay Hospital (Torquay). Assessors have been accredited and appointed and arrangements have been made for further training to ensure a consistent approach. An assessment coordinator has been appointed to undertake central coordination of the application process, organise the panel to consider applications, liaise with assessors, match candidates to exam dates and other associated duties. Further details will be published in due course. The accreditation process will be managed and quality assured by the Accreditation Panel.

Queries about the accreditation process should be addressed to Professor Roger Barton, Chair, Accreditation Panel (j.r.barton@ncl.ac.uk), 0191 2932576, or Mrs Lynn Coleman, Assistant Director, NHS Cancer Screening Programmes,
(lynn.coleman@cancerscreening.nhs.uk).

Figure 1 Accreditation process



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Published Papers

Bowles, C.J., Leicester, R., Romaya, C., Swarbrick, E., Williams, C.B. and Epstein, O. (2004) A prospective study of colonoscopy practice in the UK today: are we adequately prepared for national colorectal cancer screening tomorrow? *Gut* **53**(2):277-83.

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Shah, S.G. and Saunders, B.P. (2005) Aids to insertion: magnetic imaging, variable stiffness, and overtubes. *Gastrointestinal Endoscopy Clinics of North America* **15**(4): 673-86.

Ell, C., Fischbach, W., Keller, R., Dehe, M., Mayer, G., Schneider, B., Albrecht, U. and Schuette, W. (2003) A randomized, blinded, prospective trial to compare the safety and efficacy of three bowel-cleansing solutions for colonoscopy. *Endoscopy* **35**(4): 300-4.

Electronic/Web Based Media

http://www.practicalcolonoscopy.org.uk/
The content is aimed at both beginners and experts. It attempts to illuminate some of the mysteries involved in achieving complete, comfortable and safe colonoscopy, and aid further understanding by seeing other experts in action. (registration required). Unconditional sponsorship by Proctor & Gamble.

'Colonoscopy' - The DVD
Olympus Optical Co. Tokyo

'Polypectomy and Electrosurgery Techniques' – VHS/CDROM
St. Mark's Hospital - written and presented by Dr B.P Saunders

'Dysplasia in UC' - DVD
St. Mark's Hospital – Dr Suzuki, Dr Arebi, Dr Brian Saunders

Web Based Professional Guidelines

BSG Guideline for informed consent for endoscopic procedures
http://www.bsg.org.uk/pdf_word_docs/consent.pdf

BSG Guideline on Safety and Sedation for Endoscopic Procedures
http://www.bsg.org.uk/pdf_word_docs/sedation.doc

BSG Antibiotic Prophylaxis in Gastrointestinal Endoscopy
http://www.bsg.org.uk/pdf_word_docs/prophylaxis2001.pdf

ASGE Guideline on the management of anticoagulation and antiplatelet therapy for endoscopic procedures.
http://www.asge.org/nspages/practice/patientcare/sop/preparation/2002_antiCoag.pdf

BSG Guideline after the removal of colorectal adenomatous polyps
http://www.bsg.org.uk/pdf_word_docs/ccs3.pdf

BSG Guideline for the Management of Inflammatory Bowel Disease
http://www.bsg.org.uk/pdf_word_docs/ibd.pdf

BSG Guidance on large bowel surveillance for people with two first degree relatives with CRC or one first degree relative diagnosed with CRC under the age of 45.
http://www.bsg.org.uk/pdf_word_docs/ccs7.pdf

BSG Guideline for screening and surveillance of asymptomatic colorectal cancer in patients with IBD.
http://www.bsg.org.uk/pdf_word_docs/ccs4.pdf

NICE Referral for Suspected Cancer Guideline
http://www.nice.org.uk/page.aspx?o=261649

APPENDIX 1

ACCREDITATION PANEL

Purpose

The main purposes of the Accreditation Panel are:

- to advise the NHS BCSP on the process of assessment and accreditation of screening colonoscopists
- to oversee the quality assurance of the accreditation process

The Accreditation Panel will report to the national office of the NHS BCSP and will have primary responsibility for ensuring bowel cancer screening is provided by safe, competent, high quality colonoscopists. The panel is quorate when at least four people are present

In order to achieve the objectives outlined in the terms of reference below, the panel membership will invite/ include representatives from the JAG, the BSG, and the ACP. It will comprise a secretary, four colonoscopists from the bowel cancer screening programme colonoscopy quality assurance group including an accredited assessor and a training lead. It will be chaired by the education advisor to the National Endoscopy Training Programme.

The Panel will be informed by input from the representative bodies and professionals above, data on candidates from the application, assessment, and accreditation process, assessor and candidate evaluations, and external assessor reports.

The secretary will collate data on the candidates, administer and collate the evaluations from assessors and candidates, as well as arranging and supporting the appointment and input of an external assessor, who will be a colonoscopist of good standing with experience of assessment.

Terms of Reference

1. To determine and advise the NHS BCSP on strategic direction for the development, recruitment, assessment and accreditation of screening colonoscopists.
2. To develop and review appropriate criteria for screening colonoscopists
3. To devise and maintain an appropriate assessment process.
4. To advise on the recruitment, induction and training of assessors.
5. To receive and review applications from, and assessment data about, candidates, and to compare them to agreed criteria for accreditation.
6. To advise the NHS BCSP about candidates who meet the criteria for accreditation
7. To receive and review accredited screening colonoscopists' annual performance data and advise the NHS BCSP on renewal of accreditation.
8. To monitor and quality assure the assessment and accreditation process.

These terms of reference will be reviewed annually.

Date of First Issue: June 2006
Date of Amendment: n/a
Date of Next Review: June 2007

APPENDIX 2

SELECTION AND TRAINING OF ASSESSORS

Selection criteria

Assessors:

- should meet the same criteria as the candidates
- should be accredited
- should be very familiar with the domains and the grade descriptors, preferably by mock assessments of collaborative colleagues within local units
- must have participated in assessor induction and training
- should assess at least 6 candidates annually in the first instance.

Induction and training of assessors

Aim

- to be a competent assessor for screening colonoscopy using the DOPS assessment

Outcomes

- to be familiar with all aspects of the DOPS assessment
- to be able to use the DOPS assessment proforma
- to be able to use the grade descriptors to inform grading
- to be able to assess candidates fairly with a high degree of reliability.

Outline of training workshop

Time	Session	Activity	Lead Facilitator	Resources
9.30	Registration and coffee			
10.00	Welcome and introductions Overview of the day	Brief introductions and previous examining experience		
10.15	Preparing to assess – the DOPS form and the grade descriptors	Plenary overview of the form and descriptors Brainstorm – potential problems with DOPS		
11.00	Putting it into practice – grading a colonoscopy	Video		
11.30	Completing the process – discussion and writing feedback	Plenary presentation		
12.00	Grading colonoscopies	Practical grading of real-time procedures and pair discussion		

13.00	*Lunch*			
13.45	Grading colonoscopies	Practical grading of real-time procedures and pair discussion		
15.45	Pulling it all together	Plenary feedback around practical experiences		
16.00	Close			

APPENDIX 3

BRIEFING & INSTRUCTIONS FOR ASSESSORS

We would be extremely grateful if you could please make every effort to put the candidates at ease – even very senior and experienced colonoscopists find this a nerve-wracking and challenging experience. Please help us give the process a good name by upholding the very highest standards of professional behaviour.

MCQ

Please inform the candidates that the MCQ is positively marked, and that no marks are subtracted for incorrect answers. Therefore it will have no effect on their scores whether or not they tick "Don't know" or get an answer wrong – the outcome is the same, no mark scored.

DOPS

Choice of case

Please make every effort to ensure that the patients you select:

- have fully consented to being involved in the assessment, including information about the presence of two assessors
- are unlikely to be particularly challenging for the candidates, e.g. previous very difficult, painful or failed procedure, known severe diverticular disease
- are wholly appropriate in terms of co-morbidity; and
- that there are reserve patients available.

Please also ask the candidates how they would like the endoscopy room set up, and make arrangements for their preferences to be accommodated (position of viewing screen, scope trolley, sedatives and analgesics available etc).

Please record the degree of difficulty of the case on the DOPS form at the end of the procedure, and take this into account in the assessment, as below.

Procedure

1. Be familiar with the assessment domains and the grade achievement descriptors.

Note: domain 3 outlines the standards to be met; it is implicit that these are met and more if a grade of 4 is awarded: not all the descriptors are re-iterated in the grade 4 section.

2. Have the relevant BSG and other guidelines available – the candidate may wish to refer to them, and this is perfectly acceptable.

3. The pre-endoscopy patient documentation (endoscopy checklist) containing past medical and medication history and allergies should be made available to the candidate.

4. You **must** be present for the whole assessment. Please remind the candidate that:
   - they have 45 minutes to complete the entire procedure
   - consent should take no more than 5 minutes

- if they are failing to progress, or are judged to be at significant risk of causing a complication, that the assessors will take over the case (see 12 and 13 below, and section 5.3 of the guidance)
- there will be a maximum of 10 minutes for immediate feedback.

5. In the assessment, **do not teach or correct** the candidate. Do not interfere with the procedure except in extreme circumstances – see below.

6. Concentrate on the technique – the assessment is of their skills, not the completion of the colonoscopy – in theory it is perfectly possible for them to meet the set criteria yet perform two incomplete colonoscopies.

7. There is no need for them to demonstrate the full range of manoeuvres if they are progressing easily with good visualisation (e.g. colonoscope handling skills, position change) just to show that they can.

8. Candidates may be allowed to miss small (<5mm) polyps and still meet their criteria for screening. Candidates should however be asked to mention any lesions that they have seen but are leaving alone.

9. The descriptors are for your guidance and to help standardise assessment. They should be used sensibly. Some aspects of a domain may be irrelevant to cases in an assessment: for example a patient may have no pathology, nor require any therapy – a grade 3 or 4 can still be awarded in these domains.

10. You must take account of the difficulty of the case in assigning grades

11. Especially if you are giving grades 1 or 2, be sure to write detailed notes on the feedback sheets. These will be very important if there is a challenge to the assessment.

12. If the candidate requests assistance for a difficult case, please give advice; if advice is inappropriate or fails to help, attempt to complete the procedure. Please reassure the candidate that this does not automatically mean that they will not meet the set criteria. Make your judgement on their performance taking into account the difficulty of the case.

13. Only in exceptional circumstances should the assessment be suspended. This should be invoked only if you and your co-examiner agree that the patient is in danger of significant harm.

14. Make your assessment independent of the other assessor, record your grades according to the set criteria, make your decision, and record a global expert evaluation as well – this will help us to validate the assessment. Please adhere to the set criteria, even if you disagree with them – if that is the case, please make detailed comments using the evaluation forms below.

15. You should then discuss the assessment in private with the second assessor. If there are discrepancies between your grading (this is highly likely), please discuss this and make some comments. Record the reasons underpinning these comments in detail on the back of the assessment form. Under no circumstances should you adjust your grades.

16. Discuss and agree the specific feedback that you will give to candidates, and complete the detailed DOPS feedback form between the two of you.

17. Communicate the results and specific feedback to the candidate in private. Please make sure that they clearly understand what you are recommending to the panel.

The two DOPS assessment forms (one from each assessor) (Appendix 6) and the detailed feedback form to the candidate (one only) (Appendix 7) must then be passed to the Accreditation Panel for formal accreditation. The Panel will collate all information and evidence, and will make a formal recommendation to the NHS BCSP for accreditation. The candidates will be provided with their grades and a copy of the detailed feedback form.

In addition, please ensure that the candidates complete an evaluation form, and that both assessors complete an evaluation form (one each). These are crucial to the validation of the assessment.

APPENDIX 4

ACCREDITATION OF SCREENING COLONOSCOPISTS
APPLICATION FORM

Name:

Post held:

Qualification:

GMC/Registration No:

Screening centre:

Date of JAG visit: (*new screening centres – a JAG visit is required before submission of an application)*

Years in post:

Work address:

Telephone no. Email address:

The following will give some idea of your colonoscopic practice. The major criteria are denoted by asterisks. For the other data it should be noted that there are no single "pass or fail" criteria at this stage and the application will be considered as a whole.

Have you participated or taught on any colonoscopy related courses, eg Basic Skills in Colonoscopy, TTT etc? (please give details)

……
……
……

Please give details of the following:

1. Approximate lifetime colonoscopic experience (expected to be >1000)
   ……

2. Lifetime perforation rate:
   diagnostic (number)……
   therapeutic (number)……

Accreditation of screening colonoscopists

In an audit of your last 12 months colonoscopic procedures, please provide the following information:

3. *Number of colonoscopies(expected to be greater than 150, but supervised and private endoscopies count

…….

4. *Mean sedation levels (under 70 years / over 70 years)

Target median sedation levels<5 mg midazolam and <50 mg pethidine in <70 yrs (<2.5 mg midazolam and < 25 mg pethidine in > 70 yrs)

Midazolam ……/……

Pethidine ……/……..

Other ……...../.....

5. *Completion rate on intention to treat basis (expected to be 90% or greater) …….

(please supply details of incomplete examinations on a separate Word document)

6. *Documentation of polyp detection and removal rate in this 12 month series (expected to be greater than 20%) (last year's consecutive cases) ……...

7. Complications of this series if any:

Complication	**Number**	**Percentage of total procedures**
Vasovagal attacks		
Significant bleeding		
Over-sedation with use of reversal agents		
Need for unplanned admission		
Others (state)		

Statement
We confirm that, to the best of our belief, that the information submitted above & the supporting data are true.
Candidate Signed: Print name:
Endoscopy manager / Sister Signed: Print name:
Consultant colleague/ Clinical Director, Endoscopy Signed: Print name:

Please email together with the appropriate audit data to:

linda.beard@nhs.net

The signed copy to be posted to;

Linda Beard

Coordinator – Accreditation of Screening Colonoscopists

Endoscopy Training Centre

Torbay Hospital

Lawes Bridge

Torquay

TQ2 7AA

It is essential that all applications are completed in full and submitted with the necessary supporting documentation to satisfy the required criteria for accreditation.

Incomplete applications will not be accepted.

APPENDIX 5

ADVICE TO CANDIDATES

Twelve month audit

Please give your colleagues sufficient time to look through your audit and the supporting evidence – you *must* have this counter-signed by both colleagues.

N.B. You do not need to supply the actual evidence to the Assessment Panel or Assessment Centre.

Written assessment

Read up the relevant BSG and other guidelines beforehand.

Prepare by re-reading one of the standard practical guides/ texts, if you feel you might benefit.

The MCQ is positively marked only. Thus, no marks are subtracted for incorrect answers. Therefore it will have no effect on your scores whether or not you tick "Don't know" or get an answer wrong – the outcome is the same, no mark scored.

Topics covered in multiple choice questions

- Patient consent
- Safe sedation
- Colonic anatomy and attachments relevant to colonoscopy insertion
- Bowel preparation
- Bowel cancer screening rationale and methodologies
- Insertion technique
- Examination technique
- Lesion recognition
- Dye spraying
- Polypectomy / EMR
- Managing complications
- Managing early cancer
- Surveillance protocols
- Colonoscopic instrumentation and accessories

DOPS

- Be familiar with the assessment domains and the achievement descriptors
- Assist your preparation by asking colleagues to observe you and give you feedback based on the DOPS form. **We strongly recommend that you do this on multiple occasions prior** to the assessment. **We also recommend that you arrange similar preparation at a training centre**
- You are entitled to have the endoscopy room set up in the way you prefer – please discuss this with the assessors, who should be aware of this.
- Similarly you are entitled to use the same drugs etc. as you normally would.
- A magnetic imager and viewer will usually be available – please inform the assessors if you would like to see the images. We recommend that if you are not used to using the imager that you avoid looking at the images for the assessment – they can be very distracting.
- In the assessment, make sure you may wish to make it obvious to the examiners what you are doing when you do certain things, especially if it may not be obvious to them. For example, outline the indications and co-morbidity, tell them you are checking the oxygen saturation or vital signs, or when you are using anticlockwise torque or suction.
- You may be allowed to miss small(<5mm) polyps and still meet the criteria for screening. You should however mention any lesions that you have seen but are leaving alone.
- Concentrate on the patient and your technique – the assessment is of your skills, not the completion of the colonoscopy – it is perfectly possible to meet the set criteria yet perform two incomplete colonoscopies.
- There is no need to use the full range of manoeuvres if you are progressing easily with good visualisation (e.g. colonoscope handling skills, position change) just to show that you can.
- You do not need to talk the assessors through the procedure, or to explain what you are doing if you prefer not to.
- To help with management plans, the current guidelines (e.g. for polyp follow up) will be available for reference.

At the end of the assessment, the assessors will, after an interval, give you feedback in private. They will tell you either that they feel that you have met the criteria, or that you have not yet met the criteria for screening colonoscopy. They may make, in both cases, some observations for further development. The assessors have a maximum of 10 minutes for this – any request for further feedback must be submitted to the Accreditation Panel.

Please complete the evaluation form. It will help us to develop and validate the assessment if you could be as open, honest and professional as possible, whatever the result of the assessment. We depend on the evaluations heavily.

APPENDIX 6

Accreditation of Screening Colonoscopists – DOPS Form

Candidate: …… Assessment Centre …….. ……
Date of Assessment ……/…../……. Assessor 1……..
Assessor 2……..

• Major criteria	o Minor criteria

Scale: 4 – Highly skilled performance
3 - Competent & safe throughout procedure, no uncorrected errors
2 – Some standards not yet met, aspects to be improved, some errors uncorrected
1 - Accepted standards not yet met, frequent errors uncorrected
N/A – Not applicable

Criteria	Score	Comments
Assessment, Consent, Communication • Obtains informed consent using a structured approach - Satisfactory procedural information - Risk & complications explained - Co-morbidity - Sedation - Opportunity for questions		
• Demonstrates respect for patient's views and modesty during the procedure		
• Communicates clearly with patient throughout, including the results of the procedure with appropriate management and f/u plan		
Safety & Sedation • Secure IV access		
• Gives appropriate dose of analgesia and sedation and ensures adequate oxygenation and monitoring of patient		
• Demonstrates good communication with the nursing staff, including dosages & vital signs		
Endoscopic Skills during insertion & withdrawal o Uses correct procedure to check the endoscope function before intubation		
o Performs PR		
• Maintains luminal view, avoiding blind insertion		
• Demonstrates awareness of patient's consciousness and pain during the procedure and takes appropriate action		
o Employs torque steering		
o Uses distension, suction & lens washing appropriately		
• Recognises & logically resolves loop formation		
o Uses position change, abdominal pressure and		
o stiffener appropriately		
o Completes examination in reasonable time		
Diagnostic & Therapeutic Ability • Adequate mucosal visualisation		
• Recognises caecal landmarks or incomplete examination		
• Accurate identification & management of pathology		
• Uses diathermy and therapeutic techniques appropriately and safely		
• Recognises & manages complications appropriately		

Case difficulty

Extremely easy	Fairly easy	Average	Fairly difficult	Very challenging
1	2	3	4	5

Accreditation of screening colonoscopists

Criteria for Screening Colonoscopist Accreditation
To become an accredited screening colonoscopist, the candidate must finish the two cases having achieved the following in the major and minor criteria:

Major (14 domains) Grade 3 or 4 across all domains with the following provisos: • No grade 1's or 2's.	All domains grade 3&4 ☐ No grades 1 or 2 ☐
Minor (6 domains) Satisfactory grade or above, across all domains with the following provisos: • Maximum of four grade 2's when summated across the four cases • No grade 1's	≤ four grade 2's across four cases ☐ No grade 1's ☐

If a candidate manages these levels, they meet the set criteria for screening colonoscopy.

Please also complete the expert global evaluation below – this will be used to validate the process, and will not be used in assessing the candidates.

Confidential: Expert Global Evaluation - Overall judgment
In order to help with setting standards and validating the process, please give your expert global assessment ***independent*** of the above grading – in other words, do you personally judge that the colonoscopist is ready to become an screening colonoscopist. Please check one of the two boxes below.

The candidate: should be accredited for screening colonoscopy ☐
should not yet be accredited for screening colonoscopy ☐

Signed:

Assessor 1…….…….

Assessor 2…….…….

CRITERIA FOR ACCREDITATION AND GRADE DESCRIPTORS

To become an accredited screening colonoscopist, the candidate must finish the cases having achieved the following in the major and minor criteria:

Major (14 domains)
Satisfactory grade or above, across all domains with the following provisos:

- No Borderline or Unsatisfactory grades

Minor (6 domains)
Satisfactory grade or above, across all domains with the following proviso:

- Maximum of 4 Borderline grades
  or
- 2 Unsatisfactory grades when summated across the two assessors; i.e. a U is equivalent to 2 B's

GRADE DESCRIPTORS FOR DOPS

Descriptors for each grade in all four domains are given below to improve consistency of grading. The key descriptor level is "Grade 3". "Grade 4" assumes achievement of all components at the "3" level and some achievement above this.

The descriptors set expectations for the performance in each domain, but should be used as a guide – colonoscopists do not have to meet all criteria in each descriptor to achieve a grade in that domain.

Assessment, Consent and Communication

4 – Complete and full explanation in clear terms including proportionate risks and consequences with no omissions of significance, and not unnecessarily raising concerns. No jargon. Encourages questions by verbal and non verbal skills and is thoroughly respectful of individual's views, concerns, and perceptions. Good rapport with patient. Seeks to ensure procedure is carried out with as much dignity and privacy as possible. Clear and appropriate communication throughout procedure and afterwards a thorough explanation of results and management plan.

3 – Good clear explanation with few significant omissions, covering key aspects of the procedure and complications with some quantification of risk. Little jargon, and gives sufficient opportunity for questions. Responds to individual's perspective. Aware of and acts to maintain individual's dignity. Appropriate communication during procedure including warning patient of probable discomfort. Satisfactory discussion of results and management plan with adequate detail.

2 – Explains procedure but with several omissions, some of significance. Little or no quantification of risk, or raises occasional unnecessary concerns. Some jargon and limited opportunity for questions or sub-optimal responses. Incomplete acknowledgement of individual's views and perceptions. A few lapses of dignity only partially or tardily remedied. Occasional communication during the procedure and intermittent warnings of

impending discomfort. Barely adequate explanation with some aspects unclear, inaccurate or lacking in detail.

1 – Incomplete explanation with several significant omissions and inadequate discussion, lacking quantification of risks or raising significant fears. Uses a lot of jargon or technical language; minimal or no opportunity for questions. Fails to acknowledge or respect individual's views or concerns. Procedure lacks dignity and there is minimal or no communication during it. Explanation of results and management is unclear, inaccurate or lacking in detail without opportunity for discussion.

Safety and Sedation

4 – Safe and secure IV access with doses of analgesia and sedation according to patient's age and physiological state, clearly checked and confirmed with nursing staff. Patient very comfortable throughout. Oxygenation and vital signs monitored continually as appropriate, remaining satisfactory throughout or rapid and appropriate action taken if sub-optimal. Clear, relevant and proactive communication with endoscopy staff.

3 – Secure IV access with a standard cannula and appropriate dose of analgesia and sedation within current guidelines, checked and confirmed with nursing staff. Patient reasonably comfortable throughout, some tolerable discomfort may be present. Oxygenation and vital signs regularly monitored and satisfactory throughout, or appropriate action taken. Clear communication with endoscopy staff.

2 – IV access acceptable with just satisfactory analgesia and sedation incompletely confirmed or checked with nursing staff, patient too sedated or too aware and in discomfort. Oxygenation and vital signs monitored but less frequently than appropriate or parameters occasionally unsatisfactory with action taken only after prompting or delay. Intermittent or sub optimal communication with endoscopy staff.

1 – Insecure or absent IV access or butterfly used; inadequate or inaccurate check of analgesia and sedation. Patient significantly under- or over-sedated or needing use of a reversal agent because of inappropriate dosaging. Patient in discomfort much of the time, or significant periods of severe discomfort. Oxygenation and vital signs rarely or inadequately monitored and mostly ignored even if unsatisfactory. Minimal or significantly flawed communication with endoscopy staff.

Endoscopic Skills During Insertion and Withdrawal

4 – Excellent luminal views throughout the vast majority of the examination, with judicious use of "slide-by". Skilled torque steering and well judged use of distension, suction and lens clearing. Rapid recognition and resolution of loops. Quick to use position change or other manoeuvres when appropriate. Immediately aware of patient discomfort with rapid response. Smooth scope manipulation using angulation control knobs and torque steering.

3 – Check scope functions, performs PR. Clear luminal view most of the time or uses slide-by appropriately. Appropriate use of the angulation control knobs. Uses torque steering adequately. Aids progress using distension, suction and lens washing. Recognises most loops quickly and attempts logical resolution. Good use of position changes to negotiate difficulties. Aware of any discomfort to patient and responds with appropriate actions. Timely completion of procedure, not too quickly or too slowly for the circumstances.

2 – Omits scope check or PR. Luminal views lost a little more than desirable or uses slide-by a little too long or frequently. Could torque steer usefully more often or more effectively. Some under or over distension or lack of lens washing. Recognises most loops with reasonable attempts at resolution. Use of position change or other manoeuvres occasionally late or inappropriately. Aware of and responsive to patient but may be slow to do so. Procedure slightly too fast or too slow.

1 – Omits to check scope or rectal examination. Luminal views frequently lost for long periods and pushes on regardless. Little or no use of torque steering. Under- or over-distension of bowel, or fails to attempt lens clearing. Recognises loops late or not at all and little or no structured attempt to resolve them. Inappropriate or no use of position change or other manoeuvres. Barely aware of patient's status, or very tardy / inappropriate / no response to discomfort. Completes examination too quickly or takes far too long.

Diagnostic and Therapeutic Ability

4 – Excellent mucosal views throughout the majority of the procedure. Recognition of all caecal landmarks present or rapidly identifies incomplete examination. Faecal pools fully suctioned. Retroflexes in rectum. Thorough assessment and accurate identification of pathology present. Skilled and competent management of diathermy and therapeutic techniques. Rapid recognition and appropriate management of complications.

3 – Adequate mucosal visualisation with only occasional loss or sub-optimal views unless outwith control of endoscopist (eg stool, severe diverticular disease). Faecal pools adequately suctioned. Attempts to retroflex in rectum. Correctly identifies caecal landmarks or incomplete examination. Accurately identifies pathology and manages appropriately according to current guidelines. Correct and safe use of diathermy and therapeutic techniques. Rapid recognition of complications with safe management.

2 – Mucosal views intermittently lost for more than desirable periods. Recognises most caecal landmarks present or eventually identifies an incomplete examination. Most pathology identified with occasional missed or mis-identified lesions. Just acceptable use of diathermy and therapeutic tools with some sub optimal use. Delayed or incomplete recognition of complications or sub-optimal management.

1 – Frequent or prolonged loss of mucosal views. Incorrect identification of caecal landmarks, or fails to recognise incomplete examination. Misses significant pathology, or inappropriate management that may endanger patient or contravenes guidelines. Unsafe use of diathermy and therapeutic techniques. Fails to recognise or significantly mis-manages complications to the detriment of the patient.

APPENDIX 8

DOPS FEEDBACK FORM

To be viewed in conjunction with the DOPS assessment form and comments.

Candidate's name ……**Date of assessment** ……

Relative strengths

1.

2.

3.

Areas for focus or what candidate may do differently next time

1.

2.

3.

Suggested development needs; areas for focus at base Trust; /additional comments

APPENDIX 9

CONTINUED ACCREDITATION

Criteria

- To undertake a minimum of 150 screening colonoscopies per annum
- To submit quality monitoring data on an annual basis, and to continue to meet the application criteria
- To maintain an acceptable level of complications over a prolonged period, below the national average as defined in recent published series (Bowles et al, 2004).

The status of accredited screening colonoscopists will be reviewed by the Accreditation Panel against these criteria on an annual basis. Accreditation will be renewed if the criteria are met.

If the criteria are not met, the Panel may recommend one of the following actions:

Conclusion	**Action**	**Conditional upon**
No real concerns	Renew accreditation	Continued data monitoring annually
Likely to be natural variation in performance	Renew accreditation	Continued data monitoring at more frequent interval
Variation in performance that may benefit from peer support	Renew accreditation	Peer support & development
Sufficient variation in performance to merit re-assessment	Renew accreditation	Peer support, development, leading to DOPS
Significant concerns, meriting intensive support and re-assessment	Suspend accreditation until repeated assessment	Peer support, development, leading to DOPS
Significant concerns, meriting intensive support and re-assessment	Suspend accreditation; repeat application	Full repeat application after specified minimum interval
No evidence submitted	Suspend accreditation until evidence reviewed	Submission of evidence within 28 days