BCSA Bowel Cancer Screener Accreditation

Accreditation of BCSA Bowel Scope screening endoscopists

BCSA guidelines

Part of the JAG programme at the RCP

JAG Joint Advisory Group on GI Endoscopy

Royal College of Physicians

Version control sheet

Accreditation of BCSA Bowel Scope screening Endoscopists	
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Applies to	Prospective candidates for accreditation; BCSA mentors; screening centres; SQASs

Version	Description of change	Source of update	Author	Date
V1.7	Updates to various sections	Routine update	LB	September
V1.8	Updates following policy changes	BCS Accreditation panel meeting	RB/ LB	April 2014
V 1.9	Updated to include clarification on DOPS and suspension of Full accreditation	Full accreditation has been suspended	RB/ LB	June 2014
V 2.0	Major revisions	Removal of provisional accreditation and introduction of limit for MCQ attempts.	JAG office	September 2015
V 2.1	Minor revisions	Note on use of trainers data for applicants clarified	JAG office	October 2015
V 2.2	Amendment to section 5.4	Terminology amended from mentor/mentee to trainer/trainee	LB	03 February 2016
V2.3	Amendments following introduction of new assessment forms and updates to guidance on training on bowel scope BCSA list and amendment to bibliography section.	BCS Accreditation panel meeting	JAG office	April 2017
V2.4	Updates to various sections	BCS Accreditation panel meetings 2017	JAG office	December 2017

Table of Contents

1. Introduction

The NHS Bowel Cancer Screening Programme (NHS BCSP) commenced in July 2006. Owing to the known variability in colonoscopic skills, strict criteria have been developed for the accreditation of screening endoscopists to minimise the risk of complications and inaccurate and incomplete examinations, and this has been demonstrated to be reliable and valid[1]. With the introduction of Bowel Scope, a similarly robust mechanism has been established to ensure that patient safety is paramount and the continued high standards of the Bowel Cancer Screener Accreditation programme are maintained.

The JAG office manages the administrative functions of the Bowel Cancer Screener Accreditation (BCSA) process on behalf of the NHS BCSP. The Joint Advisory Group for GI Endoscopy (JAG) was established under the Academy of Medical Royal Colleges and now has a number of colleges and societies with an interest in endoscopy as members who are responsible for agreeing and setting policy and strategy and advising its constituent bodies and other significant organisations (such as the GMC, DH, and NHS) on standards and quality in endoscopy. The JAG is hosted by the Royal College of Physicians.

There are several advantages to this accreditation process, to both the endoscopy unit and the individual endoscopists involved. Accreditation is an essential part of preparations for the implementation of local screening. It also provides opportunities to demonstrate high-level lower GI endoscopic skills and improve the local endoscopy service. The Bowel Scope screening accreditation process leads to an individual being declared competent to act as a Bowel Scope screening Endoscopist.

2. Accreditation Panel

The JAG BCS Accreditation Panel advises PHE on the process of assessment and accreditation and assures the quality of this process. The panel's terms of reference are given in the download centre of the BCSA website.

3. Selection and Training of Mentors

Details of the training requirements for mentors are provided in Appendix 1. Briefing and instructions for assessors are given in Appendix 2.

4. Application Criteria and Process

Applications are made online through the Screening Assessment and Accreditation System (BCSA) website (www.bcsa.thejag.org.uk). For any enquiries on the criteria and process please email askjag@rcplondon.ac.uk.

Please note that accredited BCSA screening colonoscopists are approved to undertake bowel scope screening without needing to go through the Bowel Scope specific assessment process.

1

[1] **Barton RJ, Corbett S, Van Der Vlueten C.** English Bowel Cancer Screening Programme and the UK Joint Advisory Group for Gastrointestinal Endoscopy The validity and reliability of Direct Observation of Procedural Skills assessment tool: assessing colonoscopic skills of senior endoscopists. *Gastrointestinal Endoscopy 2012, 75: 583-590*

Bowel Scope application criteria:

- Candidates must be fully registered with an appropriate professional body.
- There is no necessity for an endoscopist in the programme to be a nurse or doctor, but they must be registered as a health care professional. This means that they are able to work unsupervised and take upon themselves responsibility for their own professional actions and practice.
- Be attached to a screening centre. The screening centre director or programme manager must complete a 'New Screener Request Form - Bowel Scope' to request the additional screening endoscopist. The form should be downloaded from the download centre of the BCSA website. The form then needs to be sent via email to askjag@rcplondon.ac.uk.

Once approved, the BCSA administrator in the JAG office will create an account for the candidate to apply online at www.bcsa.thejag.org.uk. An automated email from bcsa@jagserver.co.uk will be sent to the candidate confirming the application arrangements. Online applications must be completed and criteria met in full prior to submission. No paper applications will be accepted.

- Have a permanent contract within the NHS for at least 12 months
- If the candidate is a pre-CCT trainee, they are required to provide evidence they have Deanery Permission to apply to be a BCSA Bowel Scope Screening Endoscopist.
- Work in a site that has been approved to provide BCSA screening
- Has JAG certification (in Flexible Sigmoidoscopy and/or either provisional or full Colonoscopy). If you trained overseas or before the JETS programme you will need to demonstrate your competence by keeping record of your performance data and demonstrating your KPI's.
- Have a minimum lifetime experience of 350 lower GI endoscopic examinations
- Have a minimum of 150 independent lower GI examinations, required in the 12 months prior to the submission of an application. These can include observed cases but any observer or trainer cannot have offered advice or taken over the scope. These procedures must have taken place after the candidate has completed JAG certification (in Flexible Sigmoidoscopy and/or either provisional or full Colonoscopy).
- Record performance data including;
    - Lifetime perforation rate
    - Polyp detection rate in the last 12 months
    - Polyp retrieval rate in the last 12 months
    - Complications during your Lower GI endoscopic practice in the last 12 months (including number of cases requiring surgical intervention post endoscopy, number showing significant bleeding, number which needed unplanned admission and any other complications).

  This audit must be verified and signed off by the endoscopy unit sister or manager and by a senior colleague/clinical director. Both should have been invited to inspect the raw data.

- Submitting an application for the accreditation process is part of the on-going quality assurance of the BCSA and the data from applications and assessments may be used for evaluation and audit purposes.

- Be observed undertaking polypectomy and there is a requirement to submit 4 formative DOPyS with the application. The 4 DOPyS which need to be submitted as part of the application process may be signed off by a trained mentor, an endoscopy trainer or the internal assessor. The DOPyS used in the application must be signed off within 12 months of the application being submitted.

Using the July 2016 DOPyS forms the candidate must be scoring as ‘competent for independent practice’ overall.

To support applicants to obtain DOPyS, it is permissible for a procedure to be recorded and then for the DOPyS form to be completed using a recording. If a video is used for DOPyS assessment, the applicant and person signing off the DOPyS should both be present when it is completed. Applicants should be encouraged to obtain DOPyS as soon as the screener request form has been submitted. Applicants must complete the 4 DOPyS prior to submission of the application form.

Please note that candidates who do not complete their application within 12 months of commencing the process will be required to start the application process from the beginning.

5. Pre-Accreditation Preparation

5.1 It is advisable, but not mandatory, that candidates attend a polypectomy course. If you wish to attend one of these they can be accessed via the JETS website (www.jets.nhs.uk) searching by course type, or by contacting the endoscopy training centres directly.

5.2 Candidates must have a BCSA trained mentor assigned to them prior to application. The name of the mentor must be detailed in the screener request form sent to the JAG office.

5.3 Candidates should have a minimum of three meetings with their mentor preparing for their accreditation and for the role as a Bowel Scope screening Endoscopist. This should include observing scoping .The mentor is not necessarily a trainer or assessor but can share their experiences and help in the preparation process. The mentor would usually, but not necessarily, be based at the same screening centre as the applicant.

5.4 The BCS Accreditation Panel has agreed that it is inappropriate to use BCSA bowel scope lists for routine training in flexible sigmoidoscopy. Bowel Scope lists may be used by aspirant Bowel Scope screening endoscopists to gain experience, provided the individual is JAG certified (in Flexible Sigmoidoscopy and/or either provisional or full Colonoscopy). The aspirant screener should have started the application process to become a BCSA screening endoscopist (with a new screener request form having been submitted to JAG) and should already be in a position to submit audit data showing they meet the required KPIs. The individual must be committed to going through the assessment process with an assessment date booked in the following three months.

The trainer (who must have attended a JAG approved 'train the colonoscopy trainer' course, and must be an active screener) must be confident about the level of technical competency of the aspirant screener before experience can be gained on Bowel scope lists. The trainer should be confident that the candidate is of an appropriately high level to ensure quality and comfort. The trainer must accept the responsibility to properly supervise the aspirant screener.

The performance data from the lists will be attributed to the accredited screening Endoscopist on BCSS. For the candidate these lists can count towards numbers which can be recorded on the Unit's Endoscopy Reporting System and JETS. This dual use of data will be out with the BCSS KPI reports and not influence the continued programme quality monitoring.

Please note that BCSA colonoscopy list should never be used for routine training.

5.5 Data outcomes from any training will be assigned to the trainer on the BCSA website.

5.6 The BCS accreditation panel has agreed that BCSA patients can only be used when supporting candidates in preparation leading up to a BCSA assessment.

5.7 BCSA patients must not to be used for BCSA assessments or pre-accreditation training courses.

5.8 Assessment by the candidates mentor would constitute a conflict of interest. A mentor cannot act as an assessor for their mentee.

5.9 A candidate cannot be assessed by an individual who has been involved in a preparatory training day.

6. Accreditation Assessment Process

6.1 Acceptance of applications and assessment booking arrangements

Applications will be checked by the JAG administration team. Applications which meet the criteria, as specified in the application form, will be offered available bowel scope assessment dates at a BCSA Bowel Scope Assessment Centre via the BCSA website. A candidate's application that fails to meet the criteria will be referred back to the candidate. In ambiguous cases, the application will be referred to the Chair of the JAG BCS Accreditation Panel for review.

Please note that the application form must be signed, scanned and then emailed to the JAG office. The candidate will not be permitted to attend the DOPS assessment if the application form is not signed and will forfeit the assessment fee.

Candidates must book an assessment within 3 months of their application being approved (where possible). Should an assessment not be booked within this time period the application will be withdrawn from BCSA.

Candidates should aim to book onto assessments at least 10 weeks prior to an assessment date.

Candidates working for a screening centre or screening site linked to an assessment centre are not eligible to undertake their DOPS assessment at these venues as this may represent a conflict of interest. Any such connection should be declared at the time of negotiating an assessment date.

The JAG administration team manages the application process, and will liaise with the screening or assessment centre regarding establishing assessment dates and also the booking of assessors. The accreditation process is managed and quality assured by the JAG BCS Accreditation Panel.

Once an assessment date has been confirmed; withdrawal by the candidate giving less than 8 weeks' notice will render the candidate liable to the assessment fee as stated by the assessment centre.

If the minimum number of candidates required to make an assessment day viable is not reached, the assessment day will be cancelled and the candidates notified. A minimum of 8 weeks' notice from the assessment date will be given by the JAG Office. An alternative assessment date will be offered to the candidate as soon as possible.

6.2 Multiple-choice questions (MCQ) assessment

The MCQ is an online multiple choice questionnaire. It must be taken under supervised test conditions. Candidates have 1-hour to attempt 60 multiple-choice questions. It is based largely on lesion recognition and management of a case. The current pass mark is 60%.

The MCQ can be taken (supervised) anytime within 6 weeks of the DOPS/DOPyS assessment, and no more than 1 week after the DOPS/DOPyS assessment. The MCQ should be taken at the candidate's own screening centre if attempted prior to the assessment date. The third attempt at the MCQ must be made on the same day, or after the DOPS assessment to ensure this does not result in the assessment being cancelled at short notice.

The MCQ can be attempted a maximum of 3 times within 12 months from the date of the first assessment. To allow for reflection and improvement between attempts, the candidate must leave 2 weeks between attempts.

If a candidate does not pass the MCQ in 3 attempts, they are required to wait until 12 months have elapsed from the first attempt and will be required to reapply for the programme in full and resit both the DOPS assessment and the MCQ exam.

A list of topics is included in Appendix 3.3. A reading list for candidates who wish to prepare for the written assessment appears in the bibliography.

6.3 Direct observation of procedural skills (DOPS) and direct observation of polypectomy skills (DOPyS)

The second part of the assessment involves each candidate completing two consecutive cases using DOPS and DOPyS (where relevant). The assessment will be supervised by two assessors, both of whom are trained BCSA assessors. One must be internal and one external to the assessment centre and both of whom will be present in the endoscopy room.

It is not mandatory to use a magnetic imager for Bowel Scope Screening accreditation assessments. If, however, the candidate routinely uses an imager, and would prefer to use this during a Bowel Scope Screening accreditation assessment, this would be entirely acceptable.

Viewing the magnetic imager is permitted but not obligatory; candidates should be advised that if they are unfamiliar with viewing the image it might be counterproductive to do so. However, assessors may wish to view the images to aid analysis and feedback.

Any information leaflets received by the patient should be made available to the candidate. The pre-endoscopy patient documentation (endoscopy checklist), containing past medical and medication history and details of any allergies should be made available to the candidate.

The candidate will be assessed taking consent, inserting the scope, examining during withdrawal, applying any appropriate therapy and discussing results and management with the patient. If polyps are encountered and are suitable for removal during the examination, the candidate will be expected to remove them, although this can be discussed at the time.

The DOPS assessment will be conducted according to defined criteria. The assessors will determine whether the candidate:

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

To guide assessors, the generic JAG approved DOPS assessment form is divided into four domains: pre-procedure, procedure post procedure and ENTS (endoscopic non- technical skills). Each includes sub-domains for discrete areas of practice. Descriptors outlining the level of achievement associated with achieving each domain is available on the DOPS form. Any domains which are not required for the bowel scope DOPS (e.g. sedation) should be marked as "N/A". To pass the DOPS assessment, candidates must score 'achieved' (or N/A where applicable) in each individual item of the DOPS form.

Polypectomy will be assessed using the DOPyS form (a polypectomy-specific DOPS). This form is also available in the BCSA website. In the event that more than one polypectomy is performed during a case, each will be scored using the DOPyS. To pass the DOPyS, each of the sections must have an overall score of 'achieved', or where relevant 'does not apply'.

From July 2016, new DOPS and DOPYs forms have been introduced to improve the assessment process. These forms are now to be used on all BCS accreditation assessments. Exemplar forms and further information on the updated forms can be found in the download section of www.bcsa.thejag.org.uk.

The DOPS assessment lasts approximately 30 minutes, this includes obtaining consent, patient preparation, report writing and discussion. The extent of the examination should be reached in 15 minutes after which time the internal assessor will take over and complete the case. If there is an unexpected burden of pathology to deal with the assessment may be extended at the assessors' discretion, provided the candidate is proceeding satisfactorily.

Candidates may be allowed to miss small (< 5 mm) polyps and still meet the screening criteria. Candidates should, however, mention any lesions that they have seen but have chosen to leave. 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'; indeed, the assessors themselves might be unable to fully complete the procedure. If, at any time, the assessors agree that an assessment is endangering the patient they may suspend it. This will be taken to indicate that the candidate does not yet meet the criteria. All candidates will be alerted to this policy prior to the assessment. In the unlikely event of a case where both assessors have serious concerns about the competence of the endoscopist, they will advise the candidate of those concerns.

6.4 Feedback to candidates

At the end of the assessment the assessors will complete the DOPS assessment form. Using the DOPS feedback form they will also record written feedback on specific areas of good practice and on areas for further training and development. Provisional results and feedback will be given to candidates in private at the time of the assessment; this will take a maximum of 10 minutes.

Once all elements of the assessment are complete the results will be entered on to www.bcsa.thejag.org.uk by the assessor. The assessment forms will also be scanned and emailed to the BCSA administrator at the JAG office for scrutiny of the outcome.

Assessors will recommend either that the candidate be accredited or that they undergo a period of further endoscopic professional development followed by a second assessment undertaken by a different assessor pairing.

Feedback following the assessment will be provided to the candidate, their mentor and their screening centre director.

6.5 Candidates meeting the criteria

If all the criteria are met the candidate will be accredited and informed of the result by email.

Accredited candidates cannot commence screening Bowel Scope procedures until they have received their letter confirming their status. The candidate should give a copy of the full certificate of accreditation to the screening centre programme manager for records and quality assurance.

Following accreditation, best practice would be for the first two Bowel Scope Screening lists to be performed accompanied by a mentor or an experienced Bowel Scope Endoscopist.

6.6 Candidates not meeting the criteria

If the candidate does not meet the criteria at the DOPS/DOPyS assessment, the assessors will make recommendations on further development and training needs as listed on the DOPS feedback form. Results will be assembled by the BCSA administrator on behalf of the NHS BCSP and candidates will be informed by letter from the JAG Office.

If a candidate does not meet the criteria at their first assessment they are eligible for one more attempt in the 12-month period (a maximum of 2 attempts in total). During DOPS assessment retakes, the internal and external assessors must be different from those who led the first DOPS assessment. If they fail to meet the criteria at that second attempt and they wish to reapply to the programme, they are required to wait until 12 months have elapsed from the first attempt and will be required to reapply for the programme in full and resit both the DOPS assessment and the MCQ exam.

The MCQ can be attempted a maximum of 3 times within 12 months from the date of the first MCQ assessment. To allow for reflection and improvement between attempts, the candidate must leave 2 weeks between attempts.

If a candidate does not pass the MCQ in 3 attempts, they are required to wait until 12 months have elapsed from the first attempt and will be required to reapply for the programme in full and resit both the DOPS assessment and the MCQ exam.

6.7 Right of appeal

Candidates may appeal against the assessment process but not the judgment of the assessors.

8. Criteria for continued accreditation

Programme KPIs will be monitored by the regional screening QA service (SQAS). Failure to meet required standards as deemed by SQAS will result in notification to the accreditation panel. The accreditation panel will then inform the screener and screening centre director that accreditation has been withdrawn. Once accreditation has been withdrawn the colonoscopist will be required to wait 12 months before being able to reapply for accreditation.

8.1 Guidance on Bowel Scope endoscopists in the BCSA who have a break in their continuity of service

There is an expectation that Bowel Scope accredited endoscopists will begin screening as soon as possible (within 3 months) after their successful accreditation. In exceptional circumstances it may be accepted that a delay in commencing screening may be delayed for no more than 12 months. If a bowel scope endoscopist does not start screening following 12 months of being awarded accreditation, they would need to reapply and pass both the MCQ and DOPS assessments again.

Bowel Scope endoscopists are also required to have a minimum of 1 dedicated screening session allocated to their job description and to perform a minimum of 300 Bowel Scope procedures within the programme annually, to enable effective audit. However in some instances (e.g. a sabbatical) a break in service may exceed 12 months and the required number of Bowel Scope procedures may not be achieved. If this occurs, the screening endoscopists undertaking flexible sigmoidoscopy outside the BCSA should continue to audit their practice in detail including polyp detection, retrieval rates, and complication rates and submit returns. If they continue to meet the current BCSA QA Bowel Scope endoscopist criteria they may resume screening on their return to the BCSA, with agreement of the regional Professional Clinical Advisor (PCA) for colonoscopy, local QA and service lead. Endoscopists are also required to have a substantive NHS contract.

On returning to the programme the Bowel Scope endoscopist must undertake one list under the observation of a BCSA screening endoscopist.

It is the responsibility of the local screening centre and QA team to ensure that any screening endoscopist is up to date with current guidance and competent to re-enter the programme following a break in service. If a period of re-training or mentorship is required, this should be completed before rejoining the screening programme.

Once an individual has returned to the screening programme they will be subjected to the exactly same QA measures as those without any service break.

Provided their period outside the BCSA does not exceed 6 months, Bowel Scope endoscopists who do not maintain their flexible sigmoidoscopy practice (e.g. maternity leave) may resume screening immediately on their return to the BCSA after local agreement with local PCA and service lead. An individual may be advised to undertake further training or initial list(s) with a mentor if deemed appropriate.

If the time outside the BCSA is 6 months or longer, at least the first list of Bowel Scope procedures should be performed with a mentor, along with any other measures deemed necessary by local PCA and service lead.

9. Enquiries

Queries about the accreditation process should be addressed to the BCSA administrator at the JAG office by email at askjag@rcplondon.ac.uk or telephone 020 3075 1620.

Bibliography

Reference books

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Saunders BP, Shah SG. Magnetic imaging of colonoscopy. In: Waye JD, Rex DK, Williams CB (eds) *Colonoscopy Principles and Practice*. Malden, MassachusettsMA, Blackwell, 2003: 265–275.

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Published papers

Bowles CJA, Leicester R, Romaya C, Swarbrick E, Williams CB, Epstein O. A prospective study of colonoscopy practice in the UK today: are we adequately prepared for national colorectal cancer screening tomorrow? *Gut,* 2004, 53(2): 277–283.

Ell C, Fischbach W, Keller R, Dehe M. A randomized, blinded, prospective trial to compare the safety and efficacy of three bowel-cleansing solutions for colonoscopy. *Endoscopy*, 2003, 35: 300–304.

Gupta S, Anderson J, Bhandari P, McKaig B, Pullan R, Rembacken B, Riley S, Rutter M, Valori R, Vance M, van der Vleuten CPM, Saunders BP, Thomas-Gibson S. Development and Validation of a Novel Method for Assessing Competency in Polypectomy: Direct Observation of Polypectomy Skills (DOPyS). *GastrointestEndosc* 2011; 73(6): 1232-9

Saunders BP. Colon tumours and colonoscopy. *Endoscopy*, 2005, 37: 1094–1097.

Shah SG, Saunders BP. Aids to insertion: magnetic imaging, variable stiffness, and overtubes. *Gastrointestinal Endoscopy Clinics of North America*, 2005, 15: 673–686.

ASGE Guideline on the management of anticoagulation and antiplatelet therapy for endoscopic procedures

Electronic/Web-based media

www.bcsa.thejag.org.uk
This website now contains endoscopic images, video clips, web pages, and the curriculum for the multiple-choice questions assessment. Registered candidates will have access, and this is available via the "learning resources" tab.

Williams C. *Colonoscopy: the DVD.* Olympus Optical, Tokyo, 2002. Available via - https://stmarkshospital.org.uk/shop/videos/colonoscopy-the-dvd

Arebi N, Suzuki N, Saunders BP. *Dysplasia in UC* (DVD). Arebi N, Suzuki N, Saunders BP. St Mark's Hospital, 2005.
http://www.stmarksacademicinstitute.org.uk/resources/dysplasia-in-uc/

The JAG QA Training Working Group are working to produce a comprehensive set of core endoscopy e-learning modules to support training. These will be hosted and accessed via the e-learning for health platform. To log in, go onto the e-LfH website http://www.e-lfh.org.uk/home/. Then Select 'Programmes' and then Select 'Endoscopy'. Then follow instructions to register by either Selecting 'How to access' or the red 'Register' button on the top right.

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

BSG Guideline for the management of inflammatory bowel disease
http://www.bsg.org.uk/pdf_word_docs/ibd.pdf

Guidelines for colorectal cancer screening and surveillance in moderate and high risk groups (update from 2002)
http://www.bsg.org.uk/images/stories/docs/clinical/guidelines/endoscopy/ccs_10.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

NHS BCSP Publication on Quality Assurance Guidelines for Colonoscopy
Rutter MD, Chilton A. *Quality Assurance Guidelines for Colonoscopy*. NHS Cancer Screening Programmes, 2011 (NHS BCSP Publication No 6).

Appendix 1 Role and training of mentors

The role of the mentor is to:

- prepare and support new (& existing) colleagues
- facilitate training and encourage personal professional development
- Offer support on endoscopic practice and technique, if there are problems in the assessments or in clinical practice.

With the introduction of Bowel Scope screening mentors also be expected to prepare and support aspirant Bowel Scope endoscopists for the NHS Cancer Screening Programme.

Criteria to be a BCSA mentor

Mentors will need to:

- be a fully accredited screening colonoscopist or experienced Bowel Scope endoscopist
- TCT trained and be supported by their screening centre director

and

- meet the BCSA QA standards for colonoscopy or Bowel Scope
- have attended any form of mentorship training (generic mentorship training provided by local trust/organisation

Mentors cannot be the assessor for their mentee

Appendix 2 Briefing and instructions for assessors

We would be extremely grateful if you could make every effort to put candidates at ease; even senior and experienced endoscopists can find assessment nerve-racking. Please help us to give the process a good name by upholding the very highest standards of professional behaviour.

MCQ

Please inform candidates that they have 60 minutes to complete the MCQ and that the MCQ assessment is marked positively; no marks are subtracted for incorrect answers.

The MCQ must be completed under exam conditions and all efforts should be made to ensure that the candidate does not breach this. Failure to complete the exam in an appropriate manner should be reported to the BCSA Panel and may result in exclusion from the programme.

If the assessor chooses to delegate the invigilating of the exam to another member of the team, please ensure that they are aware of the above instruction.

DOPS

Choice of case

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

- Age range matched cases if possible
- 55-60 for bowelscope
- 60-75 for BCSA
- Exclude patients who have failed a previous procedure due to difficult technical intubation
- Exclude patients who have had any colonic surgery which will directly affect the assessment
- Exclude patients who are on a surveillance protocol (IBD, polyps)
- Exclude patients who have previously had a failed procedure due to bowel prep issues
- Appropriate for the procedure in terms of their co-morbidity
- Wholly appropriate in terms of co-morbidity.
- Please also ensure that reserve patients are available if needed (minimum of 2 cases for whole day of assessments, minimum of one reverse case for half day assessments).
- It is strongly recommended that another member of staff in the department is available on the day, to perform procedures on any unused reserve cases, ensuring the assessors remain free.

Process for patients

- Please ensure that patients are aware they will need to be fully consented by the candidate and of the presence of two assessors during the assessment. This is irrespective of any pre-assessment they may have already had.

Process for candidates

- Please ask the candidates how they would like the endoscopy room set up and make arrangements for their preferences to be accommodated, e.g. position of viewing screen and scope trolley.

- Candidates must be aware that any Endoscopy Checklist or WHO checklist is not a substitute for formally assessing the patient and any checklist will not contribute to any part of the DOPS assessment.

- At the end of the procedure please record its degree of difficulty on the DOPS form and take this into account when assessing the candidate, as outlined below.

Procedure

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

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 details of allergies should be made available to the candidate.

4. You must be present for the whole assessment. Please remind the candidate that they have 30 minutes to complete the entire procedure.

5. It is advised that a completed consent should take no more than 5 minutes.

6. If they are failing to progress, or are judged to be at significant risk of causing a complication, the assessors should take over the case.

7. There will be a maximum of 10 minutes for immediate feedback.

8. Please do not teach or correct the candidate during the course of the assessment. Do not interfere with the procedure except in extreme circumstances.

9. Concentrate on the technique; it is the candidate's skills that are being assessed rather than the completion of the Bowel Scope. It is theoretically possible for a candidate to meet the set criteria despite having performed two incomplete examinations

10. If they are progressing easily and with good visualisation candidates are not required to demonstrate the full range of manoeuvres (e.g. colonoscope handling skills, position change) simply to show that they can.

11. Candidates who miss small (<5mm) polyps may still be deemed to have met the criteria for screening. However they should be asked to mention any lesions they saw but chose to leave.

12. If one or more polypectomies is performed, a DOPyS form should be filled in for each. All parameters should be completed.

13. Be sure to write detailed notes on the feedback sheets, especially when the candidate has not achieved the criteria; they will be invaluable if the assessment is challenged.

14. Please give advice if a candidate asks for help with a difficult case. If the advice is inappropriate, or fails to help, attempt to complete the procedure. Do reassure the candidate that this does not automatically imply failure to meet the set criteria.

15. Take into account the difficulty of the case when judging the performance.

16. The assessment should be suspended only if both mentors agree that the patient is in danger of significant harm.

17. Make your assessment independently of the other assessing mentor, record your grades in the light of the set criteria, make your decision, and include your global expert evaluation: 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 give your reasons on the assessment form).

18. You should then discuss the assessment in private with the second mentor. If (as is likely) your grades occasionally diverge, please discuss this and add a comment to the assessment form, recording the reasons behind the comment in detail on the back of the form. Under no circumstances should you adjust your grades.

19. The assessors should discuss and agree the specific feedback that will be given to candidates, and complete jointly the detailed DOPS feedback form.

20. Communicate provisional results and specific feedback to candidates in private. Please ensure that they clearly understand what you are recommending to the Panel and emphasise that this recommendation must be formally ratified by the chair on the Panel's behalf.

    The assessors will input the result of the assessment and feedback into BCSA and the two DOPS (and any DOPyS) assessment forms must be scanned and emailed to the BCSA administrator at the JAG office. The BCSA administrator checks the data and the results are finalised. (For candidates who have not yet met the criteria for accreditation, see section 6.6) If all the criteria are met the candidate will be accredited and informed by letter with their confirmed grades and a copy of the detailed feedback form.

Assessing and scoring using the new DOPS/DOPyS forms

21. The new summative assessment forms require assessors to complete a score for every item on each form used during an assessment.

    You must ensure that you complete all sections of the form. Failure to do so will lead to a delay in the candidate receiving their results as the form will be sent back to assessor to complete.

    NB. The descriptors are for your guidance and to help standardise assessment; they should be applied judiciously. If aspects of a domain may be irrelevant to the case under assessment e.g. if a patient has no pathology please use N/A when scoring the 'Pathology management' criteria.

22. The forms are a competency framework and the associated descriptors ensure that assessments are as objective as is possible.

23. You must take account of the difficulty of the case when completing the assessment form.

24. Candidates will receive a score of
- achieved (√)
- not achieved (x)
- or does not apply/ not applicable (N/A).

25. The standard required to pass is competent not excellent. It is considered that each of the individual items on the form are a basic component of the procedure and associated necessary skills and qualities needed to perform a safe competent procedure. Candidates are therefore expected to pass each item. As with any summative assessment, the candidates will be aware that if they fail to meet the standard required, then they will not be recommended for certification. Candidates should be aware that the chances of successful accreditation are improved with appropriate pre-assessment training.

Scoring DOPyS

26. If therapy is performed then a DOPyS form must be completed. Each polypectomy must have a separate complete score completed. At the end of the procedure and overall score is assigned for the polypectomies:
    - achieved (√)
    - not achieved (x)
    - or does not apply/ not applicable (N/A).

27. It is this score that is transferred to the DOPS form in the therapy (DOPyS) box item.

28. When completing the DOPyS forms it is important to understand that a candidate can fail in one or more items within a section and still pass if the overall assessment for that section is deemed to be a pass.

29. It is the overall score that counts towards the formal accreditation result. It is important that an assessor can justify an overall 'achieved' score for DOPyS, if the candidate is assigned 'not achieved' scores by the assessors. Completion of the comments box for these items is mandated for the assessors so that the overall score can be understood by the Accreditation Panel.

Exceptional circumstances

30. It is recognised that in in a stressful situation, some individuals can make errors. Often these are quickly recognised or corrected or rectified on subsequent procedures. Whilst the candidates are informed they must successfully achieve each item, in exceptional circumstances assessors can suggest the candidate is approved for certification despite not reaching the required standard. This is should very much be an exception in assessments. Any such assessment must be supported by comment in the boxes in which the candidate failed to reach the required standard, with a further fuller explanation in the text box on the submitted assessor declaration. This can be further supplemented by additional text if deemed necessary.

Appendix 3 Advice to candidates

3.1 Twelve-month audit

Please give your colleagues sufficient time to look through your audit and the supporting evidence. You *must* have this countersigned by both colleagues.

Please note that you do *not* need to supply the evidence itself to the Assessment Panel.

3.2 Written assessment

Read through the relevant BSG and other guidelines in preparation for the assessment. In addition, re-read one of the standard practical guides or texts if you feel it might benefit you.

The MCQ is marked positively; no marks are subtracted for incorrect answers.

3.3 Topics covered in multiple choice questions

- Patient consent
- Colonic anatomy and attachments relevant to insertion
- Bowel preparation
- Bowel scope rationale and methodologies
- Insertion technique
- Examination technique
- Lesion recognition
- Polypectomy
- Managing complications
- Managing early cancer
- Endoscope decontamination, 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 and DOPyS forms. **You are strongly recommended to do this several times before the assessment.** (This is in addition to the DOPyS which have to be submitted with your application).
- You are entitled to have the endoscopy room set up in the way you prefer; please make your wishes known to the assessing mentors, who should be aware of this.
- If an imager is available (and compatible colonoscopes are being used in the accreditation assessment), it is at the discretion of the candidate as to whether or not this is used. **This should be determined prior to commencement of the assessment.**
- During the assessment you should make the assessors aware of what you are doing and why, especially if it might not be obvious to them. Outline the indications and co-morbidity, for example, and tell them when 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 (< 5 mm) polyps and still meet the criteria for screening. You should nevertheless mention any lesions that you have seen but have chosen to leave.
- Concentrate on the patient and your technique. It is your skills that are being assessed not the completion of the examination; it is perfectly possible to meet the set criteria despite performing two incomplete flexible sigmoidoscopies.
- If you are progressing easily, with good visualisation, you are not required to demonstrate the full range of maneuvers (e.g. colonoscope handling skills, position change) simply to show that you can.
- To help with management plans, the current guidelines (e.g. for polyp follow-up) will be available for reference.

Once the assessment has ended the assessors will, after an interval, give you feedback in private. They will tell you either that you have met the criteria as a Bowel Scope screening endoscopist or that they feel you have not yet met them. In either case they may make some recommendations to help your further development. The assessors are allocated a maximum of 10 minutes for this; any request for further feedback must be submitted to the Accreditation Panel.

Following the assessment you will receive an email inviting you to provide feedback. Please do this, as we depend on feedback to help us to develop and validate the assessment. We would be especially grateful if you could be as open, honest and professional as possible, whatever the outcome of the assessment.

Further information regarding this report may be obtained from the JAG office at the Royal College of Physicians.

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