BCSA Bowel Cancer Screener Accreditation

Accreditation of Screening Colonoscopists

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 screening colonoscopists	
Version	1.6
Approved by	BCS Accreditation panel
Date issued	November 2011
Last review date	January 2020
Next review date	June 2020
Document purpose	Produced on behalf of the NHS Bowel Cancer Screening Programme to provide a framework for the accreditation of screening colonoscopists
Applies to	Prospective candidates for accreditation; BCSA accreditation assessors; screening centres; QARCs

Version	Description of change	Reason for change	Author	Date
1.3	Minor amendments following BCS accreditation panel meeting.	BCS accreditation panel meeting	JAG office	April 2017
1.4	Changes to various sections following BCS accreditation panel meetings in 2017	BCS accreditation panel meetings	JAG office	December 2017
1.5	Amendments to consent section with added guidance	BCS accreditation panel meetings	JAG office	December 2018

Table of Contents

1. Introduction ... 4
2. Accreditation Panel ... 5
3. Selection and Training of Assessors ... 5
5. Pre-accreditation preparation ... 7
6. Accreditation Assessment Process ... 8
  6.1 Acceptance of applications and assessment booking arrangements ... 8
  6.2 Multiple-choice questions (MCQ) assessment ... 9
  6.3 Direct Observation of Procedural Skills (DOPS) and Direct Observation of Polypectomy Skills (DOPyS) ... 9
  6.4 Feedback to candidates ... 11
  6.5 Candidates meeting the criteria ... 11
  6.6 Candidates not meeting the criteria ... 11
  6.7 Right of Appeal ... 12
7. Criteria for Continued Accreditation ... 13
  7.1 Guidance on colonoscopists in the BCSP who have a break in their continuity of service ... 13
8. Enquiries ... 14
Figure 1 Accreditation Process ... 15
9. Bibliography ... 16
  Electronic/Web-based media ... 17
  Web-based professional guidelines (accessed 29 June 2010) ... 17
Appendix 1 ... 19
  Selection and Training of Assessors ... 19
Appendix 2 ... 20
  Briefing and Instructions for Assessors ... 20
Appendix 3 ... 24
  Role and Training of Mentors ... 24
Appendix 4 ... 25
  Advice to Candidates ... 25
DOPS ... 26

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.

The JAG office, on behalf of the NHS BCSP, manages the administrative functions of the Bowel Cancer Screener Accreditation (BCSA) process which is a web based application process. 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.

There are several advantages to this accreditation process, to both the 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 colonoscopic skills and improve the local endoscopy service. In addition, it helps clinicians who wish to teach colonoscopy locally or on courses. The accreditation process, which leads to the JAG certificate of competency to perform screening derived colonoscopy, is shown in Figure 1, and has been demonstrated to be reliable and valid[1]. Please note that all forms mentioned in this document can be found on the BCSA website.

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 Assessors

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

[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 a Direct Observation of Procedural Skills assessment tool: assessing colonoscopic skills of senior endoscopists. *Gastrointestinal Endoscopy* 2012, 75: 583-590.

4. Application Criteria and Process

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

Colonoscopy application criteria:

i. Candidates must be fully registered with the General Medical Council (GMC) or appropriate professional body and must be in good standing. It is not necessary 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 must be able to work unsupervised and take upon themselves responsibility for their own professional actions and practice.

ii. Candidates must be attached to a screening centre. The screening centre director/programme manager should complete a request form for a new screening colonoscopist (available via http://bcsa.thejag.org.uk/Downloads.aspx) to seek approval for the proposed candidate from the NHS Cancer Screening Programmes (NHS CSP) national office.

   Once approved, an account will need to be created for the candidate to apply online at bcsa.thejag.org.uk. This will be carried out by the BCSA administrator in the JAG office and an automated email will be sent to the candidate confirming the application arrangements. No paper applications will be accepted.

iii. Applications must have a minimum lifetime experience of 1000 examinations.

iv. A minimum of 150 examinations is required in the 12 months prior to the submission of an application, although a proportion of these examinations are expected to be undertaken by specialist registrars (SpRs) or others under the supervision of the candidate, or in private practice.

v. Candidates should have a documented unadjusted completion rate on an intention-to-treat basis of 90% or greater over the preceding year. This may include patients with bowel resection; however patients with incomplete examinations owing to, for example, obstructing lesions or faecal obstruction will count as failures.

vi. Candidates should also have polyp detection rates of 20% or more, and meet the current criteria with respect to sedation. Evidence will be required of the complication rate of this series, including vasovagal attacks, bleeding problems, unplanned admissions and the use of reversal agents. The audit should be verified and signed off by the Endoscopy Unit Sister or Manager and by a consultant colleague/clinical director/medical director. Both should have been invited to inspect the raw data.

vii. All candidates must have a named BCSA mentor who is a current BCSA screener and has attended either the BCSA mentor/DOPyS training day, or a TCT course along with an in house mentorship training day.

viii. Candidates must submit four completed DOPyS forms. A BCSA mentor or local BCSA assessor may complete the DOPyS by observing four polypectomies. These do not have to be video recorded. All four must be snare polypectomies; at least one >10mm and at least one using EMR technique. All 4 DOPyS forms must be scoring as ‘competent for independent practice’ overall.

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

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

i. Pre-accreditation preparation days are not mandatory. If you wish to attend one of these they can be accessed via the JETS website (www.jets.nhs.uk) and searching by course type, or by contacting the endoscopy training centres directly to negotiate a suitable date. **If you do wish to attend a preparation day please arrange this before submitting your application.** Alternatively you may wish to make an informal arrangement with colleagues who have already been through the BCS accreditation process to undertake a direct observation of procedural skills (DOPS) with you.

ii. Candidates planning to attend a pre-accreditation preparation day should do so at least 6 weeks before the assessment date.

iii. Candidates should have a minimum of three meetings with their mentor preparing for their accreditation and for the role of a screener. 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.

iv. The panel have agreed that it is inappropriate to use BCSA lists for routine training for general colonoscopy. BCSA lists may be used for aspirant screening colonoscopists to gain experience once that they are committed to going through the assessment process with an assessment date booked in the following three month period. Aspirant screeners should already be in a position to submit audit data showing they meet the required KPIs and should have started the application process to become a BCSA screening colonoscopist (with a new screener request form having been submitted to JAG).

The trainer (who must have attended a JAG approved 'train the colonoscopy trainer' course) must be confident about the level of technical competency of the aspirant screener before experience is gained on BCSA 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 the Bowel Cancer Screening Programme IT system.

v. The BCS accreditation panel has agreed that BCSA patients can only be used when supporting candidates in preparation leading up to a BCSA assessment and not to be used for BCSA assessments or pre accreditation training courses.

Assessment by the person who carried out the pre-accreditation preparation would constitute a conflict of interest and in such cases candidates should alert the BCSA administrator at the JAG office in order to ensure different assessors for the assessment accreditation.

6. Accreditation Assessment Process

6.1 Acceptance of applications and assessment booking arrangements

Applications will be screened by the BCSA administrator at the JAG office and candidates who meet the baseline criteria outlined above will be invited for assessment at an assessment centre as part of the automated process via the BCSA website.

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 should book an assessment within three months of their application being approved. Should an assessment not be booked within this time period the application will be withdrawn.

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 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.

Assessment centres are located at:

- St Mark's Hospital (London)
- St George's Hospital (London)
- New Cross Hospital (Wolverhampton)
- Northern General Hospital (Sheffield)
- Torbay Hospital (Torquay)

All assessment centres have Olympus equipment; candidates currently using other equipment are advised to familiarise themselves with Olympus equipment before their assessment. Assessors have been accredited, appointed and trained to ensure a consistent approach. Each assessment centre has a local co-ordinator who organises the assessment days.

The BCSA administrator at the JAG office manages the application process, liaises with assessors and matches candidates to exam dates. The accreditation process is managed and quality assured by the Accreditation Panel.

Once an assessment date has been confirmed, withdrawal by the candidate with less than 8 weeks' notice will render the candidate liable to the assessment fee quoted at the time of booking.

If the minimum number of candidates required to make an assessment day viable is not reached, the assessment day may be cancelled and the candidates notified. A minimum of 8 weeks' notice of

assessment cancellation will be given by the JAG Office. An alternative assessment date will be offered to the candidate as soon as possible.

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 Accreditation Panel for review.

6.2 Multiple-choice questions (MCQ) assessment

The assessment includes a one hour multiple-choice questionnaire based largely on lesion recognition and management. A reading list for candidates who wish to prepare for the written assessment appears in the bibliography. The current pass mark is 60%.

All Colonoscopy MCQ's are undertaken on the day of the DOPS assessment in BCSA colonoscopy assessment centres.

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.

6.3 Direct Observation of Procedural Skills (DOPS) and Direct Observation of Polypectomy Skills (DOPyS)

The written assessment will be followed by a DOPS and DOPyS examination over two consecutive cases. The DOPS will be supervised by two trained assessors, both of whom will be present in the endoscopy room. 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.

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. 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.

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

Issues have occurred where a full consent is not taken as part of the assessment process. Some simple omissions have been noted by assessors, and some candidates have considered the subsequent pre-procedure WHO checklist or equivalent sufficient to cover certain aspects of the consent.

The purpose of assessing consent is:

1. Assess knowledge
2. Assess communication and other non-technical skills
3. Enable relationship to develop between endoscopist and patient

The areas that are expected to be covered by a potential screener as part of the BCSA assessment are:

- Brief overview of the procedure including need for biopsy or polypectomy
- Confirm indication and explain procedure is most appropriate investigation (if this is correct)
- Potential complications – including bleeding, perforation, missed lesions and pain (including the need to discuss stoma formation if perforation and sequelae are raised by patient)
- Option of sedation/analgesia and what effect is expected
- Relevant medical issues – cardiac and respiratory that may affect procedure or medications administered
- Any allergies
- Opportunity for patient to ask questions

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 DOPS assessment form is divided into four sections: pre- procedure, procedure, post procedure and ENTS (endoscopic non- technical skills). Each includes sub domains for discrete areas of practice. To pass the DOPS assessment, candidates must score 'achieved' (or N/A where appropriate) in each individual item of the DOPS form.

If polypectomy is performed the technique will be assessed using the DOPyS form (a polypectomy-specific DOPS). In the event that more than one polypectomy is performed during a case, each will be scored using the DOPyS form. 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 bcsa.thejag.org.uk.

The DOPS assessment lasts a maximum of 45 minutes; this includes obtaining 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 the assessment may be extended at the assessors' discretion, provided the candidate is proceeding satisfactorily.

Because colonoscopies vary considerably in difficulty and are unpredictable, completing all cases to the caecum is not required. Terminal ileal intubation is not a prerequisite for successful completion. 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 colonoscopist, they will advise the candidate of those concerns. The assessors may feel professionally obliged to alert the medical director of the candidate's Trust immediately and in confidence. Notwithstanding any immediate action taken, a full report will be made to the Accreditation Panel, who will forward any recommendations for further training confidentially to the medical director of the candidate's Trust.

6.4 Feedback to candidates

At the end of the assessment the assessors will complete the DOPS assessment form. Using the assessor declaration and candidate 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.

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 with two alternative assessors. The results will be forwarded to the BCSA administrator at the JAG office for scrutiny of the outcome. Once all elements of the assessment are complete the results will be entered on to the BCSA website by the BCSA administrator in the JAG office.

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 by email, a formal certificate will follow from the JAG Office.

Accredited candidates cannot commence screening colonoscopies until they have received their official letter from JAG. Screening centre programme managers will require a copy of this for file and quality assurance.

Successful candidates who are accredited screeners may then perform screening colonoscopy. **The first two lists must be performed with supervision from their BCSA mentor, focussing on polypectomy technique and skills using the DOPyS framework.**

6.6 Candidates not meeting the criteria

If the candidate does not meet the criteria, the assessors will make recommendations on further development and training needs as listed on the feedback form. Results will be assembled by the BCSA administrator and candidates will be informed by email 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, with two alternative assessors. If they fail to meet the criteria at that second attempt they cannot reapply until 12 months after the date of the first attempt.

During DOPS assessment retakes, the internal and external assessors must be different from those who led the first DOPS assessment.

6.7 Right of Appeal

Candidates may appeal against the assessment process but not the judgement of the assessors. Appeals should be made in writing to the Chair of the Accreditation Panel via the JAG office.

7. Criteria for Continued Accreditation

There is an expectation that BCSA accredited colonoscopists will begin screening as soon as possible (within three months) after their successful accreditation. In exceptional circumstances it may be accepted that commencing screening may be delayed for no more than 12 months. If a BCSA endoscopist does not start screening following 12 months, accreditation will only be permitted, subject to satisfactory audit data being submitted to the JAG office and approved by the chair of the accreditation panel.

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.

7.1 Guidance on colonoscopists in the BCSA who have a break in their continuity of service

In some instances (e.g. a sabbatical) a break in service may exceed 12 months and the required number of BCSA procedures may not be achieved. If this occurs, the screening endoscopists undertaking colonoscopy assessments 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 endoscopist criteria they may resume screening on their return to the BCSA, with agreement of the local Professional Clinical Advisor (PCA) for Colonoscopy and service lead. Endoscopists are also required to have a substantive NHS contract.

It is the responsibility of the local screening and PCA 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 return to the screening programme they will be subjected to the exactly same QA measures as those without any service break.

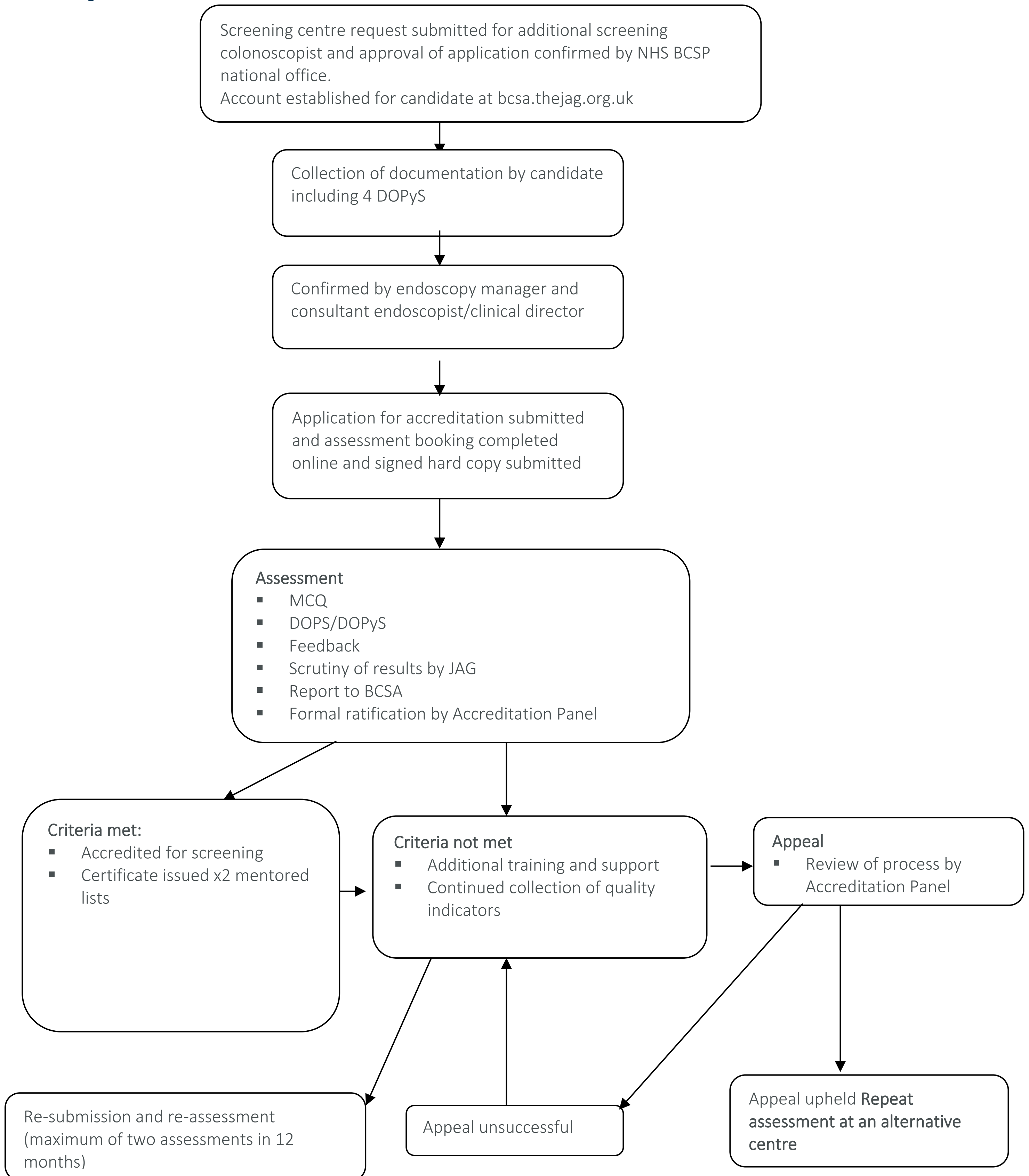
Provided their period outside the BCSA does not exceed 6 months, BCSA endoscopists who do not maintain their colonoscopy practice (e.g. maternity leave) may resume screening immediately on their return to the BCSA after local agreement with local PCA and service lead. An individual may be advised to 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 BCSA procedures should be performed with a mentor, along with any other measures deemed necessary by local QA and service lead.

8. 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.

Figure 1 Accreditation Process



9. Bibliography

Reference books

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 a Direct Observation of Procedural Skills assessment tool: assessing colonoscopic skills of senior endoscopists. Gastrointestinal Endoscopy 2012, 75: 583-590.

Cotton PB, Williams CB. *Practical Gastrointestinal Endoscopy: The Fundamentals*, 6th edition. Chichester, Sussex, Wiley–Blackwell, 2008.

Saunders BP. Colonoscopy technique. In: Classen M, Tytgat GNJ, Lightdale CJ (eds) *Gastroenterological Endoscopy*. New York, Georg Thieme Verlag, 2002: 135–150.

Saunders BP. Polyp management. In: Phillips RKS, Clarke S (eds) *Frontiers in Colorectal Surgery*. Shrewsbury, TFM, 2005: 29–44.

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.

Waye JD. Colonoscopic polypectomy. In: Tytgat GNJ, Classen M, Waye JD, Nakazawa S (eds) *Practice of Therapeutic Endoscopy,* 2nd edition. Philadelphia, PennsylvaniaPA, Saunders, 2000: 213–233.

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, McKaig B, *et al* Development and Validation of a Novel Method for Assessing Competency in Polypectomy: Direct Observation of Polypectomy Skills (DOPySGastrointestEndosc 2011; 73(6): 1232-9

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

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.

Electronic/Web-based media

http://www.screenersupport.nhs.uk
This website contains endoscopic images, video clips, web pages, the curriculum for the multiple-choice questions assessment and a discussion forum **(Registration required.)**

http://www.practicalcolonoscopy.org.uk/(this is only available on a "pay for" basis through the website. 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 experts in action.

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.

Williams C. *Colonoscopy: the DVD.* Olympus Optical, Tokyo, 2002. Available via
http://www.wolfsonendoscopy.org.uk/st-mark-multimedia-colonoscopy-the-dvd.html

Saunders BP (writer and presenter). ***Polypectomy and Electrosurgery Techniques*** (VHS/CD-ROM).
Saunders BP (writer and presenter). St Mark's Hospital, 2003.

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/

Web-based professional guidelines (accessed 29 June 2010)

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/WorkArea/showcontent.aspx?id=7142

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

NICE Referral guidelines for suspected cancer
http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10968

Appendix 1

Selection and Training of Assessors

Selection criteria

Assessors

- should meet or exceed the criteria applied to candidates
- should be accredited
- should be thoroughly familiar with the domains and the descriptors, preferably via mock assessments of collaborative colleagues within local units
- must have participated in assessor induction and training
- should assess at least six candidates annually in the first instance.

Induction and training of assessors

Aim

- To be a competent assessor for screening colonoscopy using the direct observation of procedural skills (DOPS) and direct observation of polypectomy skills (DOPyS) assessment.

Outcomes

- To be familiar with all aspects of the DOPS/DOPyS assessment
- To be able to use the DOPS/DOPyS assessment pro forma
- To be able to use the descriptors to decide whether a domain has been achieved or not. To be able to assess candidates fairly with a high degree of reliability.

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 colonoscopists can find assessments 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
- 60-75 for BCSA
- Appropriate for the procedure in terms of their co-morbidity
- 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
- Please also ensure that reserve patients are available if needed (minimum of 2 cases for whole day of assessments, minimum of one reserve 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 colonoscopy. 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).

21. 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

22. If therapy is performed then a DOPyS from 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).

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

24. 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.

25. 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

26. 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

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

Mentors will need to be:

• Be fully accredited Screening Colonoscopists
• Meet the BCSA QA standards for Colonoscopy
• Be TCT trained
• Be supported by their Screening Centre Director
• Have attended any form of mentorship training day. (Generic mentorship training provided by local trust/organisation).

Appendix 4

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 countersigned by both colleagues.
Please note that you do *not* need to supply the evidence itself to the Assessment Panel or the Assessment Centre.

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.

Topics covered in multiple choice questions

- Patient consent
- Safe sedation
- Colonic anatomy and attachments relevant to colonoscopic 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

- All assessment centres have Olympus equipment. Candidates currently using other equipment are advised to familiarise themselves with Olympus equipment before their assessment.
- Be familiar with the assessment domains and the achievement descriptors.
- Assist your preparation by asking your mentor and or screening 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 and to arrange further similar preparation at a training centre.**
- You are entitled to have the endoscopy room set up in the way you prefer; please make your wishes known to the assessors, who should be aware of this.
- You are also 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. If you are unused to viewing the images you are advised not to do so during the assessment, as it can be distracting.
- 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 colonoscopy; it is perfectly possible to meet the set criteria despite performing two incomplete colonoscopies.
- If you are progressing easily, with good visualisation, you are not required to demonstrate the full range of manoeuvres (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 for screening colonoscopy 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 complete an online evaluation. Please do this, as we depend on evaluations 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.

JAG office
Accreditation Unit
Care Quality Improvement Department
Royal College of Physicians
11 St Andrews Place
London
NW1 4LE

0203 075 1620
askJAG@rcplondon.ac.uk
www.thejag.org.uk

The publication is copyrighted to the Royal College of Physicians of London. The named service on the front page of this report may reproduce all or part of this publication, free of charge in any format or medium provided. The text may not be changed and must be acknowledged as copyright with the document's date and title specified. All images and logos contained within this report cannot be reproduced without the permission of the Royal College of Physicians.