Accreditation of Bowel Scope endoscopists

BCSP guidelines
## Version control sheet

### Accreditation of Bowel Scope endoscopists

<table>
<thead>
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<th>Version</th>
<th>1.9</th>
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<tr>
<td>Status</td>
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<table>
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<th>Reason for change</th>
<th>Author</th>
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<tr>
<td>V1.7</td>
<td>Updates to various sections</td>
<td>Routine update</td>
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<td>September 2013</td>
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<tr>
<td>V1.8</td>
<td>Updates following policy changes</td>
<td>BCSP Accreditation panel meeting</td>
<td>RB/LB</td>
<td>April 2014</td>
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<tr>
<td>V1.9</td>
<td>Update to include clarification on DOPS and suspension of Full accreditation</td>
<td>Full accreditation has been suspended</td>
<td>RB/LB</td>
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1. Introduction

The NHS Bowel Cancer Screening Programme (NHS BCSP) commenced in July 2006 and has recruited expert colonoscopists to carry out over 192,000 screening colonoscopies to date. 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 Screening Programme are maintained.

The JAG office manages the administrative functions of the Screening Assessor Accreditation System (SAAS) process on behalf of the NHS BCSP 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. 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 accreditation process leads to the JAG certificate of competency to perform screening flexible sigmoidoscopy.

2. Accreditation Panel

The NHS BCSP Accreditation Panel advises the National Office 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 SAAS 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 (SAAS) website (www.saas.nhs.uk). For any enquiries on the criteria and process please email asksaas@rcplondon.ac.uk. A sample application form is shown in Appendix 3.

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


Accreditation of Bowel Scope Endoscopists
Developed by the JAG Office on behalf of the Bowel Cancer Screening Programme © Royal College of Physicians 2013
Bowel Scope Criteria;

- Candidates must be fully registered with the General Medical Council (GMC) or appropriate professional body and must be in good standing. 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.

- Candidates must be attached to a screening centre. The screening centre director/programme manager should complete a request form for a new Bowel Scope endoscopist (shown in Appendix 4). The form should be downloaded from the [download centre of the SAAS website](http://www.saas.nhs.uk).

Once approved, an account will be created for the candidate to apply online at [www.saas.nhs.uk](http://www.saas.nhs.uk). This will be carried out by the SAAS administrator in the JAG office and an automated email from [saas@jagserver.co.uk](mailto:saas@jagserver.co.uk) will be sent to the candidate confirming the application arrangements. No paper applications will be accepted.

- Applicants must have a minimum lifetime experience of 300 lower GI endoscopic examinations, of which 150 should be unassisted procedures.

- A minimum of 150 lower GI examinations is required in the 12 months prior to the submission of an application.

- Candidates should record the polyp detection rate. 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 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 BCSP and the data from applications and assessments may be used for evaluation and audit purposes.

- All candidates should 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. Once signed off, these are valid for 12 months.

- 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 the 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 the assessment.

5. Pre-Accreditation Preparation

**Accreditation of Bowel Scope Endoscopists**

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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) and searching by course type, or by contacting the endoscopy training centres directly.

5.2 Candidates should have a BCSP trained mentor assigned to them prior to application.

5.3 It is advised that the candidate spends time with their mentor preparing for their accreditation and for the role as a Bowel Scope endoscopist. 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 panel agrees that it is inappropriate to use BCSP lists for routine training for general flexible sigmoidoscopy; however, it has agreed that Bowel Scope lists could be used to train aspirant Bowel Scope screening endoscopists committed to going through the assessment process. It would not be appropriate for a de novo but once the mentor was confident that the quality and comfort could be ensured (possibly after 100 cases), this could be undertaken on mentored lists provided that their mentor accepts the responsibility to properly train and supervise the mentee. Therefore, the mentor should be confident that the candidate is of an appropriately high level to ensure quality and comfort (suggested 100 case experience).

The performance data from the mentored lists will be attributed to the accredited screening colonoscopist mentoring the list. The candidate cannot count this data then towards their adenoma detection rate prior to application but could use completed formative DOPyS forms. This dual use of data will be out with the BCSS KPI reports and not influence the continued programme quality monitoring.

5.5 Assessment by the candidates mentor would constitute a conflict of interest

6. **Accreditation Assessment Process**

6.1 **Acceptance of applications and assessment booking arrangements**

Applications will be checked by the SAAS administrator at the JAG office and candidates who meet the baseline criteria outlined above will be allocated an assessment date at their screening centre (see appendices 11 & 12).

The SAAS administrator at the JAG office manages the application process, and will liaise with the screening centre regarding establishing assessment dates and the assessors who will carry out the assessments. The accreditation process is managed and quality assured by the accreditation panel.

A candidates’ 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 will take place at the candidate’s own screening centre under supervised test conditions, and includes a 1-hour multiple-choice questionnaire based largely on lesion recognition and management. A list of topics is included in Appendix 5. A reading list for candidates who wish to
prepare for the written assessment appears in the bibliography. The current pass mark is 60%. The MCQ can be taken (supervised) anytime within 6 weeks of the DOPS/DOPyS Assessment, and if unsuccessful may be repeated at intervals of 2 weeks.

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 (where relevant) examination over two consecutive cases. The DOPS will be supervised by two assessors, both of whom are designated mentors in the BCSP and one a trained BCSP assessor. One will be internal and one external to the screening course 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.

Even 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.

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 (Appendix 6) is divided into four domains: assessment, consent and communication; safety and sedation; endoscopic skills; and diagnostic and therapeutic ability. Any domains which are not required for the bowel scope DOPs (e.g. sedation) should be marked as “N/A”. An outline of each domain appears on the assessment form at Appendix 8. Each includes sub-domains for discrete areas of practice. Descriptors outlining the level of achievement associated with each of the four grades (4, 3, 2, 1) are provided in Appendix 7.

Polypectomy will be assessed using the DOPyS form (a polypectomy-specific DOPS). The DOPyS form and the grade descriptors are provided in Appendices 8 and 9. The only information from the DOPyS form that will be transferred to the main DOPS form is the overall competency score for a polypectomy performed during a case; this will be transferred to the ‘Uses diathermy and therapeutic techniques appropriately and safely’ section of the DOPS form.

In the event that more than one polypectomy is performed during a case, each will be scored using the
DOPyS. However, only the lowest overall competency score will be transferred to the main DOPS form. Assessors will grade candidates against the criteria and these grades will inform their final decision as to whether the candidate meets or does not yet meet the criteria.

NB; candidates may accumulate no more than two Grade 2 scores in any single minor sub-domain; further Grade 2 performance in that sub-domain is disregarded so that the principle of ‘double jeopardy’ cannot apply. 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 (Appendix 6).

Using the DOPS feedback form (shown in Appendix 10) 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.

The results will be forwarded to the SAAS administrator at the JAG office for scrutiny of the outcome. Assessors will recommend either that the candidate be accredited or that she or he undergo a period of further endoscopic professional development followed by a second assessment undertaken by a different assessor pairing.

6.5 Candidates meeting the criteria

Once all elements of the assessment are complete the results will be entered on to the SAAS by the SAAS administrator in the JAG office. If all the criteria are met the candidate will be provisionally accredited and informed by email.
6.6 KPIs for Bowel Scope screening endoscopists

Suspension of full accreditation – from June 2014 until further notice

The adenoma detection rate (ADR) in bowel scope screening has not been reaching the anticipated level of 10%.

In view of this ADR data, it has been agreed, in discussion with the JAG Accreditation Panel Chair, to suspend the submission of KPIs and the process to achieve full accreditation until the ADR data has been reviewed.

All endoscopists who have been accredited for bowel scope screening may continue to perform bowel scope screening and Screening Centre Directors and mentors should review the data from their endoscopists on ADR and extent of examination of a regular basis to ensure high level of performance within bowel scope screening.

Due to the above, until further notice the full accreditation process detailed below is not applicable.

Once the candidate has completed 100 bowel scope cases, the Screening Centre Manager should download the KPI’s from OBIEE. This should be countersigned as satisfactory by the Screening Centre Director and submitted to JAG at asksaas@rcplondon.ac.uk. Any KPI’s submitted which JAG believe are unsatisfactory will be verified by the external assessor.

If the KPI data is satisfactory, the candidate is deemed fully accredited and a letter and certificate will be issued. If the candidate is not successful in reaching the KPIs after 300 procedures or 9 months, whichever is soonest, they will need to reapply and be reassessed.

KPIs for Bowel Scope screening endoscopists

<table>
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<th>KPI</th>
<th>Comments</th>
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<tr>
<td>Cancer detection rate</td>
<td>Auditable outcome</td>
</tr>
<tr>
<td>Adenoma detection rate</td>
<td>10% of patients have ≥ 1 adenoma</td>
</tr>
</tbody>
</table>
  1. Atkins trial found 8-15% overall with twice as many in men as women.  
  2. Photodocumentation of all polyps |
| Intubation time | Auditable outcome | |
| Maximal intubation point (segment of colon; % reaching DC or SF) | Auditable outcome | 
  1. Record estimated anatomical depth of insertion AND  
  2. Record scope insertion length at point where withdrawal is commenced |
<p>| Withdrawal time | Auditable outcome | |
| Retroflexion | 90% + Auditable outcome | Photodocumentation |
| Polyp retrieval rate | 90%+ |</p>
<table>
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<tr>
<th>Comfort</th>
<th>Auditable outcome</th>
<th>Use BCSP data as most discomfort occurs in relation to sigmoid colon</th>
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<tr>
<td>Complications</td>
<td>&lt; 1%</td>
<td>1. Major post polypectomy bleeds (Levin Gut 2005)</td>
</tr>
<tr>
<td></td>
<td>&lt;1/25,000</td>
<td>2. Perforation 1 in 25-50 000 FS examinations (Levin Gut 2005)</td>
</tr>
<tr>
<td></td>
<td>diagnostic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>procedures</td>
<td></td>
</tr>
<tr>
<td>Accuracy of size</td>
<td>Auditable</td>
<td>1. % of people referred for screening colonoscopy (5% from Atkins</td>
</tr>
<tr>
<td>estimation for</td>
<td>outcome</td>
<td>trial) (2% - 8% range thought reasonable)</td>
</tr>
<tr>
<td>polyps &lt;10/10+mm</td>
<td></td>
<td>2. How many FS polyps ≥ 10mm are excised. (Pathologist will</td>
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<tr>
<td></td>
<td></td>
<td>determine post resection size therefore polyps less than</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10mm should not be referred for colonoscopy unless system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>failure)</td>
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<tr>
<td>Bowel prep quality</td>
<td>Auditable</td>
<td>Unlike FOB programme, the policy &amp; prep will be identical from unit</td>
</tr>
<tr>
<td></td>
<td>outcome</td>
<td>to unit.</td>
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**Auditable outcome = to be recorded, but no defined standard currently exists**

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

If the candidate is not successful in reaching the KPIs after 300 procedures or 9 months, whichever is soonest, then they will need to reapply and be reassessed (see note in section 6.6 regarding the suspension of full accreditation. The restriction in length of time at which a candidate can remain as provisionally accredited does not currently apply).
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 (Appendix 10). Results will be assembled by the SAAS 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 reassessment which will be arranged internally in agreement with the screening centre and the JAG office as per Appendix 11. One more attempt of the observational element of the assessment may be undertaken in the 12 month period. There is no limit to on the number of MCQ attempts. If they fail to meet the criteria at that second attempt they cannot reapply until 12 months after the date of the first attempt.

The second assessment will be undertaken by a different assessor pairing.

6.7 Right of appeal

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

7. Criteria for continued accreditation

If successful the individual should begin Bowel Scope procedures within 6 months of accreditation.

Accreditation will be maintained if the successful candidate:

- intends to undertake a minimum of 300 Bowel Scope procedures per year
- maintain a level of complications over a prolonged period that remains within national guidance as outlined by the latest national/BCSP audit data, and within the limits defined in the BCSP Quality Assurance Guidelines for Colonoscopy – BCSP publication no 6

Quality monitoring data on individuals’ performance from the bowel cancer screening reporting tool, OBIEE, will be used to confirm that the Bowel Scope endoscopist continues to meet the quality assurance criteria. Appendix 12 outlines actions that may be taken if those criteria are not met.

7.1 Guidance on Bowel Scope endoscopists in the BCSP who have a break in their continuity of service

Current guidance is that Bowel Scope endoscopists should begin screening within 6 months of their successful accreditation, and no more than 12 months after it. Bowel Scope endoscopists are also required to perform a minimum of 300 Bowel Scope procedures annually within the programme 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 BCSP 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 BCSP QA Bowel Scope endoscopist criteria they may resume screening on their return to the BCSP.
Provided their period outside the BCSP 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 BCSP. However they may wish to undertake their first few lists with a mentor.

If the time outside the BCSP is 6 months or longer, at least the first four Bowel Scope procedures (and ideally the first 10) should be performed with a mentor. The screening endoscopist and their mentors should agree the appropriate duration of the mentored re-induction into the BCSP.

8. Enquiries
Queries about the accreditation process should be addressed to the SAAS administrator at the JAG office by email at asksaas@rcplondon.ac.uk or telephone 020 3075 1620.
**Figure 1 Accreditation Process**

Screening centre request form submitted to asksaas@rcplondon.ac.uk for additional Bowel Scope endoscopist. Account established for candidate at www.saas.nhs.uk

Collection of documentation by applicant

Confirmed correct by endoscopy manager and mentor

Application for accreditation submitted and assessment booking completed online

Assessment
- MCQ
- DOPS/DOPyS
- Feedback
- Scrutiny of results by JAG
- BCSP National Office notified
- Formal ratification by accreditation panel

Criteria Met
- Provisionally accredited for screening
- Certificate of full accreditation issued following submission of satisfactory KPI data following 100 cases (see section 6.6 note)
- Continued collection of quality indicators

Criteria not met
- Additional training and support
- Continued collection of quality indicators
- Assessment can be rebooked

Appeal
- Review of process by Accreditation Panel

Re-submission and re-assessment

Appeal upheld

Appeal unsuccessful

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Bibliography

Reference books


Published papers


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Electronic/Web-based media
www.saas.nhs.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.

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.


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


NICE Referral guidelines for suspected cancer http://www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10968
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 proposed introduction of Bowel Scope screening mentors also be expected to prepare and support aspirant Bowel Scope endoscopists for the NHS Cancer Screening Programme.

Where a mentor has indicated they would be willing, they will also be invited to act as internal or external assessors for Bowel Scope Assessments, supported in this role be either an internal or external BCSP Assessor

Criteria

Mentors will need to:

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

and

- meet the BCSP QA standards for colonoscopy or Bowel Scope
- have attended a BCSA mentorship training day

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

DOPS

The main aims of the skills assessment are to ensure that the examination is safe, comfortable, accurate and complete. The identification and resolution of loops during flexible sigmoidoscopy is perhaps of less importance than during colonoscopy and the lack of access to a magnetic imager is unlikely to significantly affect the outcome of the assessment process.

The extent and quality of the examination is judged by the endoscopist who is asked to record the estimated anatomical depth of insertion and the scope insertion length at the point where withdrawal has commenced, together with the quality of the bowel prep. Although desirable to reach splenic flexure, this is an unreliable landmark (even with an imager). A magnetic imager is therefore not required to assess completeness of examination.

Choice of case

Please make every effort to ensure that the patients you select

1. have fully consented to being involved in the assessment and to the presence of two Assessors

2. are unlikely to be particularly challenging for the candidates (e.g. have not previously undergone a very difficult, painful or failed procedure or are not known to have severe diverticular disease)

3. are wholly appropriate in terms of co-morbidity.

Please also ensure that reserve patients are available if needed.

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.

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. Do note that Grade 3 outlines the standards to be met. Although it is assumed that these are met and
exceeded if a grade 4 is awarded, not all are reiterated 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 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
   - 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, the assessors should 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. Please do not teach or correct the candidate during the course of the assessment. Do not interfere with the procedure except in extreme circumstances (see 12 and 13 below).

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

7. 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.

8. 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.

9. The descriptors are for your guidance and to help standardise assessment; they should be applied judiciously. Although some aspects of a domain may be irrelevant to the case under assessment e.g. patient may have no pathology or require no therapy a Grade 3 or 4 may still be awarded in that domain.

10. If one or more polypectomies is performed, a DOPyS form should be filled in for each. All parameters should be completed. The score for overall competency at polypectomy should be transferred to the main DOPS form, in the section entitled ‘Uses diathermy and therapeutic techniques appropriately and safely’. If more than one polypectomy is completed in a single case then all DOPyS overall scores should be recorded but only the lowest score should be recorded on the DOPS form.

11. You must take account of the difficulty of the case when assigning a grade.

12. Be sure to write detailed notes on the feedback sheets, especially when giving grades 1 or 2; they will be invaluable if the assessment is challenged.

13. 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, and take into account
the difficulty of the case when judging the performance.

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

15. 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).

16. 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.

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

18. 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 four DOPS assessment forms (two from each assessor, at Appendix 6) and the detailed feedback form to the candidate (one only, at Appendix 10) must then be passed to the SAAS administrator at the JAG office. The SAAS administrator enters the data onto the SAAS and the results are calculated. (For candidates who have not yet met the criteria for accreditation, see section 5.6.) If all the criteria are met the candidate will be provisionally accredited and informed by letter with their confirmed grades and a copy of the detailed feedback form.
ACCREDITATION OF BOWEL SCOPE ENDOSCOPISTS

SAMPLE

APPLICATION FORM

Applications must be completed *online only*
via [www.saas.nhs.uk](http://www.saas.nhs.uk)
Accreditation of Flexible Sigmoidoscopist

Complete the following application answering all questions. When you have completed the application you will need to download a printable version of your application, a link for this will be provided when you have finished. The printable version will be in PDF format, you will need to have Adobe Acrobat Reader to view and print it. You need to print the application so that you can collect the necessary signatures. Once collected sign the printed and signed version including supporting documentation to the address provided at the end of the printed application form.

Please answer all questions, there are four screens to complete. You can login as many times as you need to complete the application, each screen will be saved as you progress allowing you to complete it over time if necessary.

Before completing the application form please read the Accreditation Guidelines and tick the box to confirm that you understand the guidelines and understand that anonymised data from the application and assessments may be used for future analysis.

You may change your password to a more memorable one of your choice

<table>
<thead>
<tr>
<th>Title:</th>
<th>Miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name:</td>
<td>Ann</td>
</tr>
<tr>
<td>Surname:</td>
<td>Other</td>
</tr>
<tr>
<td>Post Held:</td>
<td>Nurse Endoscopist</td>
</tr>
<tr>
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</tr>
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<td>NMC</td>
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</tr>
<tr>
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<td>Bristol Royal Infirmary</td>
</tr>
<tr>
<td>Screening Centre:</td>
<td>Bristol &amp; Weston Screening Centre</td>
</tr>
<tr>
<td>Date of JAG visit:</td>
<td>22/08/2012</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>17/06/1964</td>
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<tr>
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<td>Postcode:</td>
<td>BS2 8BW</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>0117 231231</td>
</tr>
<tr>
<td>e-mail:</td>
<td><a href="mailto:Inda.beare@nhs.net">Inda.beare@nhs.net</a></td>
</tr>
</tbody>
</table>

The following will give some idea of your Lower GI practice. The major criteria are denoted. 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.

Accreditation of Bowel Scope Endoscopists
Developed by the JAG Office on behalf of the Bowel Cancer Screening Programme © Royal College of Physicians 2013
APPLICATION FORM

Please give details of the following.

1. Lower GI experience: 300  *(approximate lifetime Lower GI experience, minimum 200)*
2. Lifetime perforation rate:
   - 0  *diagnostic (number)*
   - 0  *therapeutic (number)*

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

3. Number of Lower GI:
   - 150  *(expected to be greater than 100, but supervised and private Lower GI count)*

Save and quit  Previous screen  Save and continue
Please upload copies of 4 DOPyS formative assessment sheets:
These should have been assessed within the past 12 months. The 4 DOPyS may be signed off by a trained BCSP mentor or a TCT trained endoscopist.

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 the 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.

To upload documents click Select button, locate the file and click the Upload button. Once uploaded, if necessary you can delete the uploaded DOPyS by clicking on the red cross.

- DOPyS1.pdf
- DOPyS2.jpg
- DOPyS3.pdf
- DOPyS4.pdf

To upload documents click select button, locate the file and click the Upload button.

4. Documentation of Polyp detection in this 12 month period %:

Documentation of polyp retrieval rate in this 12 month period %:

(major criteria)

[Table and form elements]

©2014 Crown Copyright - Logout
5. Complications during your Lower GI in the last 12 months:

<table>
<thead>
<tr>
<th>Complication</th>
<th>Number</th>
<th>% of total procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasovagal attacks</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Significant bleeding (post-polypectomy bleeding requiring transfusion)</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Need for unplanned admission</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Other (state, if none please put None and enter 0’s) [none]</td>
<td>0</td>
<td>0.00</td>
</tr>
</tbody>
</table>

6. Have you attended a hands on polypectomy course? 
   [ ] Yes  [ ] No
   If yes, please provide details:

7. Please select your Mentor
   [ ] Tom Cread

8. Please indicate if you are familiar with the Olympus ScopeGuide imager equipment (also known as the magnetic imager):
   [ ] Regular use of the imager (very familiar with the imager)
   [ ] Occasional use of the imager (some familiarity with the imager)
   [ ] Very little use of the imager (e.g. just pre-BCSVA)
   [ ] Never used the imager

What to do next?
When you are happy with the answers you have given, click on the Submit button below. This will submit your application to the SAAS Administrator and create a version of the form in PDF format which you can save to your computer. If you have not already done so, be sure to install Adobe Acrobat Reader.

You should then print out the form collect the appropriate signatures, after which you should post it to the address shown at the bottom of the printed form.
Appendix 4 Screener request form

# REQUEST FOR A BOWEL SCOPE ACCREDITED ENDOSCOPIST

## Screening Centre

<table>
<thead>
<tr>
<th>FS Sites:</th>
</tr>
</thead>
</table>

## Bowel Scope Accredited Endoscopist

<table>
<thead>
<tr>
<th>Names</th>
<th>Site</th>
<th>BCSP sessions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Proposed candidate/s</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Email</th>
<th>Site</th>
<th>GMC/NMC</th>
<th>FS Sessions</th>
</tr>
</thead>
</table>

## Reason for request

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

**Requested by:** *(Clinical Director or Programme Manager)*

**Name:**

**Email:**

**Telephone:**

**Mentor:**

The JAG office will be charging the screening centres an admin fee per candidate for accreditation. This fee covers admin, quality assurance, governance, support and development.

The invoice will be sent to the clinical director/programme manager.

Please return this form to the JAG Office, Royal College of Physicians, 11 St Andrews Place, Regents Park, London, NW1 4LE
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 countersigned by both colleagues.
Please note that you do not need to supply the evidence itself to the Assessment Panel.

DOPyS
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. Once signed off, these are valid for 12 months.
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 the 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 the assessment.

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
- 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 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 as a provisional Bowel Scope screening endoscopist or that they feel you have not yet met them. In either case they may make some observations 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.
Appendix 6 Dops Assessment forms

DOPS Assessment form
Certification of screening flexible sigmoidoscopists

<table>
<thead>
<tr>
<th>Headline Criteria</th>
<th>Full Criteria outlined in Grade Descriptors</th>
<th>Score</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment, consent, communication</td>
<td>Obtains informed consent using a structured approach</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Satisfactory procedural information</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk and complications explained</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Comorbidity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sedation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opportunity for questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrates respect for patient’s views and dignity during the procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communicates clearly with patient, including outcome of procedure with appropriate management and follow up plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety and sedation</td>
<td>Safe and secure IV access</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gives appropriate idea of anaesthesia and sedation and ensures adequate oxygenation and monitoring of patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrates good communication with the nursing staff, including dosages and vital signs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopic skills during insertion and procedure</td>
<td>Checks endoscope function before intubation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Performs PR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintains luminal view / inserts in luminal direction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrates awareness of patient’s consciousness and pain during the procedure and takes appropriate action</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uses torque steering and control knobs appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uses distension, suction and lens washing appropriately</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recognises and logically resolves loop formation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uses position change and abdominal pressure to aid luminal views</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completes procedure in reasonable time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and therapeutic ability</td>
<td>Adequate mucosal visualisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recognizes landmarks or incomplete examination</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Accurate identification and management of pathology</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Uses diathermy and therapeutic techniques appropriately and safely</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Recognizes and manages complications appropriately</td>
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Case difficulty

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<tr>
<th>Extremely easy</th>
<th>Fairly easy</th>
<th>Average</th>
<th>Fairly difficult</th>
<th>Very challenging</th>
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<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

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Accreditation of Bowel Scope Endoscopists
Developed by the JAG Office on behalf of the Bowel Cancer Screening Programme © Royal College of Physicians 2013
Assessor declaration

Certification of screening colonoscopist/flexible sigmoidoscopist

To become an accredited screening endoscopist, the candidate must finish the two cases having achieved the following major and minor criteria.

DOPS STANDARDS

MAJOR DOMAINS (14 DOMAINS)

☐ We declare that the candidate received a Grade 5 or Grade 4 on all 14 major domains
☐ We declare that there are no Grade 1 or Grade 2 scores in any of the 14 major domains.

MINOR DOMAINS (6 DOMAINS)

☐ We declare that the candidate has not exceeded four grade 2’s when summed across four cases.
☐ We declare that there are no Grade 1 scores in any of the six minor domains.

CONFIDENTIAL - EXPERT GLOBAL EVALUATION

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 endoscopist is ready to be accredited for the Bowel Cancer Screening Programme.

Please check one of the two boxes below.

☐ The candidate should be certified for screening colonoscopy/flexible sigmoidoscopy (delete as appropriate)
☐ The candidate should not yet be certified for screening colonoscopy/flexible sigmoidoscopy (delete as appropriate)

ASSESSOR SIGN OFF

We certify that  

☐ Meets the DOPS criteria outlined on page one
☐ Meets the minimum DOPS standards above

<table>
<thead>
<tr>
<th>Assessor 1</th>
<th>GMC number</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessor 2</th>
<th>GMC number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Appendix 7 Criteria for accreditation and grade descriptors

To become an accredited Bowel Scope endoscopist the candidate must achieve the following grades in the major and minor criteria

**Major** (14 domains)
Satisfactory grade or above across all domains, with no Grades 1 or 2.

**Minor** (6 domains)
Satisfactory grade or above across all domains, with no Grade 1 scores and a maximum of four Grade 2s.

**Grade descriptors for DOPS**

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

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

Note that candidates may accumulate no more than two Grade 2 scores in any single minor sub-domain: after this, further Grade 2 performance is disregarded in that sub-domain so that the principle of double jeopardy cannot apply.

**Assessment, consent and communication**

4 – Full explanation in clear terms including proportionate risks and consequences with no omissions of significance, and without raising unnecessary concerns. No jargon. Uses verbal and non-verbal skills to encourage questions 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 the procedure; a thorough explanation of results and management plan after it.

3 – Good, clear explanation covering key aspects of the procedure and complications with some quantification of risk and few significant omissions. Uses little jargon and gives sufficient opportunity for questions. Responds to the individual’s perspective. Aware of and acts to preserve the 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 significant. Little or no quantification of risk, or raises occasional unnecessary concerns. Some jargon, limited opportunity for questions, or sub-optimal responses. Incomplete acknowledgement of individual’s views and perceptions. Occasional failure to preserve patient’s dignity, only partially or tardily remedied. Some 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. Fails to quantify risks or raises significant fears. Often resorts to jargon or technical language; minimal or no opportunity for questions. Fails to acknowledge or respect individual’s views or concerns. Procedure lacks respect for dignity and there is minimal or no communication during the course of it. Explanation of results and management is unclear, inaccurate or lacking in detail and leaves little or no 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, although 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 barely 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 reversal agent needed because of an inappropriate dosage. 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 – Checks 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 clearing. 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; neither too quickly nor too slowly for the circumstances.
2 – Fails to check scope or PR. Luminal views lost a little more than desirable or uses ‘slide-by’ a little too long or too often. Torque steering could be used more often or more effectively. Some under or over-distension or insufficient lens clearing. Recognises most loops with reasonable attempts at resolution. Use of position change or other manoeuvres occasionally late or inappropriate. Aware of and responsive to patient but reactions may be slow. Procedure slightly too fast or too slow.

1 – Omits to check scope or undertake rectal examination. Luminal views frequently lost for long periods but presses on despite this. 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 makes little or no structured attempt to resolve them. Inappropriate or no use of position change or other manoeuvres. Barely aware of patient’s status; responds to discomfort very tardily, inappropriately, or not at all. Completes examination too quickly or takes far too long.

Diagnostic and therapeutic ability


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

2 – Mucosal views intermittently lost for longer than desirable. Recognises most landmarks present or eventually identifies an incomplete examination. Most pathology identified with occasional missed or misidentified lesions. Just acceptable use of diathermy and therapeutic tools with some sub-optimal use. Complications recognised belatedly or incompletely, or sub-optimally managed.

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 contravene guidelines. Unsafe use of diathermy and therapeutic techniques. Fails to recognise or significantly mismanages complications to the detriment of the patient.
## Appendix 8 DOPyS Polypectomy Assessment Score Sheet

### DOPyS: Polypectomy Assessment Score Sheet

<table>
<thead>
<tr>
<th>Date:</th>
<th>Assessor:</th>
<th>Endoscopist:</th>
<th>Case ID:</th>
</tr>
</thead>
</table>

A separate sheet should be used for each case. Up to five polyps from one patient may be documented on one DOPyS score sheet.

### Optimising view of / access to the polyp:

1. Attempts to achieve optimal polyp position
2. Optimises view by aspiration/insufflation/wash
3. Determines full extent of lesion (i.e. use of adjunctive techniques e.g. bubble biopsy, NBI, dye spray etc.) if appropriate
4. Uses appropriate polypectomy technique (i.e. taking into account site in colon)
5. Adjusts/stabilises scope position
6. Checks all polypectomy equipment (forceps, snare, clips, loops) available
7. Checks (or asks assistant) to ensure closure prior to introduction into the scope
8. Clear instructions to and utilisation of endoscopy staff
9. Checks diaphram settings are appropriate
10. Photos/documents pre and post-polypectomy

### stalked polyps: General:

11. Applies prophylactic haemostatic measures if deemed appropriate
12. Selects appropriate snare size
13. Directs snare accurately over polyp head
14. Correctly selects en-bloc or piecemeal removal depending on size
15. Advances snare towards stalk as snare closed
16. Places snare at appropriate position on the stalk
17. Mobilises polyp to ensure appropriate amount of tissue is trapped within snare
18. Applies appropriate degree of diathermy

### sessile lesions / endoscopic mucosal resection: General:

19. Adequate sub mucosal injection using appropriate injection technique, maintaining views
20. Only process if the lesion lifts adequately
21. Selects appropriate snare size
22. Directs snare accurately over the lesion
23. Correctly selects en-bloc or piecemeal removal depending on size
24. Appropriate positioning of snare over lesion as snare closed
25. Ensures appropriate amount of tissue is trapped within snare
26. Tents lesion gently away from the mucosa
27. Uses cold snare technique or applies appropriate diathermy, as applicable
28. Ensures adequate haemostasis prior to further resection

### Post polypectomy:

29. Examines remnant stalk/polyp base
30. Identifies and appropriately treats residual polyp
31. Identifies bleeding and performs adequate endoscopic haemostasis if appropriate
32. Flexes, or attempts retrieval of polyp
33. Checks for retrieval of polyp
34. Places tattoo competently, where appropriate

### Polyp sizes:

<table>
<thead>
<tr>
<th>Polyp site</th>
<th>Polyp size</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAC/TC/BC/SC/Rectum</td>
<td>mm</td>
</tr>
</tbody>
</table>

### Overall Competency at Polypectomy: 4/3/2/1

### Comments:

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Accreditation of Bowel Scope Endoscopists
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## DOPyS descriptors – generic

### Appendix 9 DOPyS descriptors

#### Scale 4: Highly Skilled Performance

1. Ensures good (5-11 o'clock axis) polyp position with no errors. Attempts made at position correction throughout the procedure.
2. Maintains clear polyp views throughout the procedure.
3. Determines the full extent of the lesion, using adjunctive measures where appropriate.
4. Uses most appropriate polypectomy technique safely with no errors.
5. Maintains stable scope position throughout polypectomy. This may involve asking an assistant to hold the scope in position to provide a stable platform for polypectomy.
6. Checks all polypectomy equipment is available and functioning with correct settings prior to the procedure.
7. Checks snare prior to introduction into the scope and ensures that snare is marked appropriately on the snare handle.
8. Maintains effective communication with the staff and addresses patient’s concerns.
9. Checks diathermy settings are appropriate and ensures diathermy equipment is available and working. Ensures pad is attached to patient, foot pedal is accessible, no contraindication to diathermy.
10. Accurately photo- documents pre and post polypectomy. accurately

#### Scale 3: Competent and safe throughout procedure, no uncorrected errors

1. Maintains 5-11 o’clock axis during procedure with attempts at position correction.
2. Attempts to obtain clear polyp views through aspiration, insufflation and lens wash.
3. Determines the full extent of the lesion, may not use adjunctive measures.
4. Uses appropriate polypectomy technique safely based on size, site and morphology.
5. Adjusts and stabilises scope position prior to polypectomy.
6. Checks polypectomy equipment is available and functioning.
7. Checks snare prior to introduction into the scope and ensures handle is marked.
8. Maintains effective communication either with the staff or patient.
9. Checks diathermy settings are appropriate. Ensures diathermy equipment is available and working. Epad is attached to patient, foot pedal is accessible, no contraindication to diathermy.
10. Photo- documents pre and post polypectomy.

#### Scale 2: Some standards not yet met, aspects to be improved, some errors uncorrected

1. Does not maintain 5 11 o’clock axis. Few attempts made at position correction.
2. Clear polyp views not maintained.
3. Does not determine or visualise full extent of the polyp or fails to recognise features suggestive of malignancy.
4. Chooses inappropriate polypectomy technique.
5. Scope not stabilised adequately. Little or no attempts made at use of adjunctive techniques.
6. Does not check essential polypectomy equipment is available and functioning prior to the procedure.
7. Does not check snare functioning and marking prior to introduction into the scope.
8. Fails to give clear instructions to endoscopy staff during the procedure or ignores patient concerns.

#### Scale 1: Accepted standards not yet met, frequent errors uncorrected

1. Does not maintain polyp in the optimal position at any time during the procedure.
2. Poor polyp views throughout the procedure with no attempts at correction.
3. No attempts made at determining or visualising full extent of the polyp. Attempts polypectomy on lesions which are unlikely to be endoscopically resectable.
4. Inappropriate polypectomy technique. Uses inappropriate diathermy settings. Uses diathermy or hot biopsy technique unsafely or inappropriately.
5. Unstable scope position throughout procedure with no attempts made at correction.
6. Does not check for any polypectomy equipment
7. Does not check snare functioning and marking prior to introduction into the scope.
8. Does not communicate with the endoscopy staff or patient throughout the procedure.
9. Makes no attempt to check, or uses inappropriate diathermy settings.
# DOPyS Descriptors – stalked polyps

## Scale 1: Accepted standards not yet met, frequent errors uncorrected

11. Makes no attempt to use prophylactic measures where required.
12. Inappropriately small or large snare size used.
13. Multiple unsuccessful attempts at snare positioning over polyp head.
15. Closes snare too rapidly, cutting/shearing through the polyp stalk.
16. Poor snare position on polyp stalk, either too close to the polyp head, or too close to the base.
17. Makes no attempt to mobilise the polyp prior to diathermy where necessary. Does not check for additional trapped tissue.
18. Uses inappropriate diathermy technique causing either bleeding or burns.

## Scale 2: Some standards not yet met, aspects to be improved, some errors uncorrected

11. Attempts to use prophylactic measures where appropriate but with poor technique and uncorrected errors.
12. Snare size may be inappropriate for polyp size.
13. Multiple attempts at snare positioning over polyp head.
15. Closes snare too rapidly or in an uncontrolled fashion.
16. Poor snare position on polyp stalk.
17. Does not attempt to mobilise the polyp prior to diathermy where deemed necessary. Does not check for additional trapped tissue.
18. Inappropriate diathermy technique risking either bleeding or burns.

## Scale 3: Competent and safe throughout procedure, no uncorrected errors

11. Applies prophylactic haemostatic measures (e.g. endo-loop, clips) where appropriate with good technique.
12. Selects appropriate snare size.
13. Steers the snare over the polyp head with reasonable accuracy.
14. Correctly selects en-bloc or piecemeal removal.
15. Advances snare sheath in a controlled fashion towards stalk as snare is closed.
16. Appropriate position on stalk with snare.
17. Mobilises the polyp, e.g. to tent stalk away from mucosa and contra-lateral wall if necessary.
18. Applies appropriate degree of diathermy. Does not cause contra-lateral burns or cut through too quickly causing bleeding.

## Scale 4: Highly Skilled Performance

11. Applies prophylactic haemostatic measures (e.g. endo-loop, clips) where appropriate with excellent technique.
12. Always selects snare size appropriate to the polyp.
13. Always steers the snare over the polyp head accurately.
14. Correctly selects en-bloc or piecemeal removal.
15. Advances snare sheath slowly towards stalk as snare is closed gradually.
16. Excellent position on stalk with snare, midway between polyp head and stalk base.
17. Always mobilises the polyp to tent stalk away from mucosa and contra-lateral wall.
18. Applies appropriate degree of diathermy with no evidence of contra-lateral burns or cutting through too quickly causing bleeding.
DOPyS Descriptors-small sessile lesions/endoscopic mucosal resection

**Scale 4: Highly-Skilled Performance**

19. Accurately injects the submucosa, maintaining excellent views of the lesion.
20. Always checks for lifting and only proceeds only if the lesion lifts adequately.
21. Always selects snare size appropriate to the polyp.
22. Steers appropriately sized snare accurately over the lesion head with no errors.
23. Correctly selects en-bloc or piecemeal removal depending on size of lesion. Removes piecemeal in as few pieces as possible.
24. Accurately positions snare over lesion as snare closed gradually.
25/26. Always ensures no additional tissue is trapped within snare by gently tenting the lesion away from the mucosa and mobilising the snare.
27. Applies appropriate diathermy with no complications.
28. Always ensures adequate haemostasis prior to further resection.

**Scale 3: Competent and safe throughout procedure, no uncorrected errors**

19. Injects the submucosa, maintaining adequate views of the lesion.
20. Only proceeds if the lesion lifts adequately.
21. Selects appropriate snare size.
22. Steers appropriately sized snare accurately over the lesion head with minimal difficulty.
23. Correctly selects en-bloc or piecemeal removal depending on size of lesion.
24. Advances snare sheath in a controlled fashion towards stalk as snare is closed.
25/26. Ensures no additional tissue is trapped within snare by gently tenting the lesion away from the mucosa.
27. Applies appropriate diathermy with no complications.
28. Ensures adequate haemostasis prior to further resection.

**Scale 2: Some standards not yet met, aspects to be improved, some errors uncorrected**

19. Attempts submucosal injection but inadequate views of the lesion obtained.
20. May proceed despite parts of the lesion not lifting and inadequate attempts at further lifting.
21. Snare size may be inappropriate for polyp size.
22. Clumsy steering of snare over the lesion head.
23. Incorrectly selects en-bloc or piecemeal removal, or piecemeal removal in excessive pieces.
24. Closes snare too rapidly or in an uncontrolled fashion.
25/26. Does not ensure that additional tissue is not trapped within snare. Inadequate attempt to tent the lesion away from the mucosa.
27. Inappropriate diathermy technique risking either bleeding or burns.

**Scale 1: Accepted standards not yet met, frequent errors uncorrected**

19. Does not attempt submucosal injection. Optimal views of the lesion not obtained.
20. Does not check for lifting prior to attempting polypectomy.
21. Inappropriately small or large snare size used.
22. Clumsy steering of snare causing mucosal injury.
23. Incorrectly selects en-bloc or piecemeal removal.
24. Closes snare too rapidly, cutting/shearing through the polyp tissue.
25/26. Does not check for additional tissue trapped within snare prior to applying diathermy. No attempt to tent the lesion away from the mucosa.
27. Applies inappropriate diathermy with bleeding or burns.
28. Does not ensure adequate haemostasis prior to further resection.
DOPyS Descriptors – post polypectomy

Scale 4: Highly-Skilled Performance

29. Always examines remnant stalk/polyp base thoroughly to check for bleeding and any residual polyp tissue.
30. Identifies and resects any residual tissue accurately.
31. Identifies bleeding and performs adequate endoscopic haemostasis promptly.
32. Retrieves polyp using method appropriate to polyp’s size.
33. Checks for retrieval of entire polyp tissue and confirms retrieval with endoscopy staff.
34. Uses tattooing in the appropriate setting. Raises a bleb at appropriate site prior to switching to appropriate ink. Places appropriate number of tattoos.

Scale 3: Competent and safe throughout procedure, no uncorrected errors

29. Examines remnant stalk/polyp base to check for bleeding and any residual polyp tissue.
30. Identifies and resects any residual tissue.
31. Identifies bleeding and performs adequate endoscopic haemostasis with satisfactory immediate results.
32. Retrieves, or attempts retrieval, of polyp. May not use method appropriate to polyp’s size.
33. Attempts to check for retrieval of polyp.
34. Uses tattooing in the appropriate setting (e.g. high-risk polyp size/morphology/method of resection) but may not raise a bleb prior to switching to appropriate ink. May not place appropriate number of tattoos.

Scale 2: Some standards not yet met, aspects to be improved, some errors uncorrected

29. Makes inadequate attempt to examine remnant stalk/polyp base.
30. Does not adequately identify or treat visible residual polyp tissue.
31. Inadequately identifies or treats bleeding.
32. Inadequate attempt at retrieval of polyp.
33. Does not check for retrieval of polyp.
34. May not use tattooing in the appropriate setting. Does not raise a bleb prior to switching to appropriate dye. May not place tattoos at appropriate site. Inappropriate depth of ink, risking peritoneal staining.

Scale 1: Accepted standards not yet met, frequent errors uncorrected

29. Makes no attempt to examine remnant stalk/polyp base
30. Leaves residual polyp tissue behind.
31. Does not identify or treat bleeding.
32. No attempts made at polyp retrieval.
33. Does not check for retrieval of polyp with endoscopy staff
34. Does not use tattooing in the appropriate setting. Places tattoos at inappropriate site. Inappropriate depth of ink, risking peritoneal staining.
Appendix 10 DOPS feedback form

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

**Detailed DOPS feedback form for accreditation of screening endoscopists**

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

<table>
<thead>
<tr>
<th>Candidate’s Name</th>
<th>Date of assessment</th>
</tr>
</thead>
</table>

**Relative strengths**

1. 

2. 

3. 

**Areas for focus on what candidate may do differently next time**

1. 

2. 

3. 

**Suggested development needs, areas for focus at base Trust/additional comments:**

12 months
0 months
3 months
Immediate

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Appendix 11 Screening Centre Guidance - Arranging internal Bowel Scope accreditation assessments

It will be the responsibility of each screening centre to arrange internal assessments for their candidates to become Bowel Scope endoscopists.

The screening centre will be responsible for all costs incurred in the arrangements for the assessments.

The JAG will invoice the screening centre a fee per candidate to cover their administrative costs of the process.

Planning for an internal assessment should be undertaken to allow sufficient timeliness for internal and external assessors, JAG and candidates to comply with the application and assessment booking process (see ‘Guidance for BCSP Programme managers - Arranging assessment days for bowel scope screeners’). A suggested timescale would be that confirmation of the agreed date should be made 3 months in advance.

In order to make these assessments as economical to the screening centre as possible, a number of candidates should be assessed in one day (suggest four maximum). They will be observed undertaking two cases each.

There should be two assessors, one internal and one external. One should be a screening colonoscopist who has undertaken the BCSP DOPyS mentorship training course but has not mentored the candidate and one is an accredited BCSP assessor. The screening centre should contact the JAG office for assistant in negotiating the services of an external BCSP mentor to assess. The screening centre will be responsible for reimbursing the external assessor for their time (suggested fee for 2 PA’s + review of KPI data post 100 cases* £700 on a week day, but this would be anticipated to be charged at double time for a Saturday assessment.) and travel and accommodation expenses for attending the assessments.

Screening centres must nominate an administrator who will be responsible for coordinating the assessment day, liaising with JAG, preparing assessment paperwork, submission of completed assessment paperwork to JAG, ensuring appropriate equipment and accommodation is available for the MCQ and liaising with Endoscopy Booking on the appropriate timing of patient bookings to ensure it matches the assessment timetable. Bear in mind that honorary contracts will be required if candidates are from a neighbouring trust, and this will need to be planned for.

Each screening centre will be given full instructions on how to access and run the MCQ assessment, which will need to be undertaken during the assessment day.

Once the date of the assessments and the internal and external assessor are confirmed, the screening centre should liaise with JAG (asksaas@rcplondon.ac.uk) to confirm these details and the number of assessments which will be carried out. The JAG will then allocate approved candidates (those that have submitted an application form which meets the minimum criteria specified) to this assessment date and the SAAS system (www.saas.nhs.uk) will confirm by auto email with the screening centre, external assessor and the candidates the booking for these assessments, date and venue.

On the day of the assessments paper copies of BCSP flexible sigmoidoscopy DOPS and DOPyS forms (see appendix 6 and 8) should be completed. Following the assessments the completed forms should

Accreditation of Screening Flexible Sigmoidoscopists
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be either scanned and emailed to the JAG office at asksaas@rcplondon.ac.uk or photocopied and the originals posted FAO of the SAAS administrator at the JAG, Accreditation Department, 11 St Andrews Place, Royal College of Physicians, Regents Park, London NW1 4LE.

The JAG will upload the assessment results to the SAAS system and letters confirming the results of the assessment will be sent to the candidates.

*provisional accreditation will be maintained until the candidate has completed 100 cases and KPI data reviewed to confirm BCSP standards are met, at which point a status of full accreditation will be given (see note in section 6.6. regarding full accreditation).
Appendix 12 Screening Centre Guidance - Process for candidates for to become a Bowel Scope Endoscopist

- Screening centre email JAG with a list of candidates names and email addresses who are nominated to submit an application to become a flexi sig screener on a “New Screener Request Form” (Appendix 4).
- JAG set up SAAS accounts and auto emails sent to candidates inviting them to submit an application.
- Screening centre liaises with JAG to confirm agreed date of internal assessment and confirmed external assessor (see “Screening Centre Flexi Sig Assessment Organisation Process”).
- Candidates submit application which is approved/declined upon agreed criteria.
- JAG will book the approved candidates into the assessment date which has been agreed by the screening centre. An email with the screening centre, external assessor and the candidates the booking for these assessments, date and venue will be sent.
- Screening centre will hold assessments on the agreed date and DOPS & DOPyS forms submitted (scanned and via email or copied and originals in post).
- JAG office process DOPS & DOPyS results on SAAS and letter sent confirming assessment results.
  - Unsuccessful – may be re-assessed
  - Provisional - letter detailing that provisional accreditation is granted.
- Full accreditation is confirmed after 100 procedures have been undertaken and the external assessor has reviewed KPI data and confirmed these are satisfactory with JAG office. The KPI should be emailed to asksaas@rcplondon.ac.uk.
- If the candidate is not successful in reaching KPI’s after 300 procedures or 9 months whichever is soonest, then they will need to reapply and be reassessed.
- Screening centre managers should request a copy of the accreditation certificate for evidence for quality assurance visits.

Provisional accreditation will be maintained until the candidate has completed 100 cases and KPI data reviewed to confirm BCSP standards are met, at which point a status of full accreditation will be given.
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