Accreditation of Screening Colonoscopists

BCSP guidelines
### Version control sheet

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| **Author/ originator** | Linda Beard  
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| **Date issued** | November 2011 |
| **Last review date** | June 2013 |
| **Next review date** | June 2014 |
| **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; BCSP accreditation assessors; screening centres; QARCs |

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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.

The JAG office, on behalf of the NHS BCSP, manages the administrative functions of the Screening Assessor Accreditation System (SAAS) 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 valid1.

2. Accreditation Panel

The NHS BCSP Accreditation Panel advises JAG and the National Office of the NHS Bowel Cancer Screening Programme on the process of assessment and accreditation and assures the quality of this process. The Panel’s terms of reference are listed in Appendix 1.

3. Selection and Training of Assessors

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

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4. Application Criteria and Process

Applications are made online through the Screening Assessment and Accreditation System (SAAS) web-site. [www.saas.nhs.uk](http://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 5.

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 state-registered. This means that they must be able to work unsupervised and take upon themselves responsibility for their own professional actions and practice. It also means that the public, who are submitting to an intimate examination to which they have been invited by the NHS, are protected from individuals who may have transgressed the law or otherwise been involved in socially undesirable activity.

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 (Appendix 6) to seek approval for the proposed candidate from the NHS Cancer Screening Programmes (NHS CSP) national office.

From Sept 2013 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.

Once approved, an account will need to 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.

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 BCSP mentor who has been attended one of the BCSP mentor/DOPyS training days.

viii. Candidates must submit four completed DOPyS forms. A BCSP mentor or local BCSP 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. It is naturally expected that all four DOPyS should have an overall score of three or four (competency).

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

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 BCSP 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. (On the cancellation of assessments see section 5.1.)

iii. It is advised that the candidate spends time with their mentor preparing for their accreditation and for the role of a screener. 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 agree that it is inappropriate to use BCSP lists for routine training for general colonoscopy; however, it has agreed that BCSP lists could be used to train aspirant screening colonoscopists committed to going through the assessment process within the next 6 months. They should already be in a position to submit audit data showing they meet the required KPIs.

These selected individuals, with a designated named mentor, can now be mentored on a screening list, 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 of quality. Training centres hosting pre-accreditation preparation courses should not use BCSP screening colonoscopy lists for this training.
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 count any other data in, for example caecal intubation rates and 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.

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 SAAS 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 SAAS 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 SAAS website. 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 SAAS 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 of less than 6 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 will be cancelled and the candidates notified. A minimum of 6 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 list of topics is included in Appendix 7. A reading list for candidates who wish to prepare for the written assessment appears in the bibliography. The current pass mark is 60%.

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.

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 (Appendix 8) is divided into four domains: assessment, consent and communication; safety and sedation; endoscopic skills; and diagnostic and therapeutic ability. 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 9.

If polypectomy is performed the technique will be assessed using the DOPyS form (a polypectomy-specific DOPS). The DOPyS form and the grade descriptors are provided in Appendices 10 and 11. 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 form. 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 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 (Appendix 8). Using the form at Appendix 12 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 she or he undergo a period of further endoscopic professional development followed by a second assessment with two alternative assessors. The results will be forwarded to the SAAS 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 SAAS as a screening colonoscopist by the SAAS administrator in the JAG office.
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 BCSP 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 DOPS feedback form (Appendix 12). Results will be assembled by the SAAS 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.

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

Newly accredited screening colonoscopists should aim to begin screening colonoscopies within 12 months of accreditation. If not, accreditation will only be continued subject to satisfactory audit data being submitted to the JAG office and approved by the chair of the accreditation panel.

Accreditation will be maintained if the candidate:

- intends to undertake a minimum of 150 screening colonoscopies per year
- maintains a level of complications over a prolonged period that remains below the national average 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 IT system (BCSS) will be used to confirm that the screening colonoscopist continues to meet the application criteria. Appendix 13 outlines actions that may be taken if those criteria are not met.

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

Current guidance is that screening colonoscopists should begin screening as soon as possible after their successful accreditation, and no more than 12 months after it. Screening colonoscopists are also required to perform a minimum of 150 screening colonoscopies annually within the BCSP 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 screening colonoscopies may not be achieved. If this occurs, screening colonoscopists undertaking colonoscopy outside the BCSP should continue to audit their colonoscopy practice in detail – including caecal intubation rates, polyp detection and retrieval rates, sedation levels and complication rates – and submit audit data. If they continue to meet the current BCSP QA colonoscopy standards they may resume screening on their return to the BCSP.

Provided their period outside the BCSP does not exceed 6 months, screening colonoscopists who do not maintain their colonoscopy 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 screening colonoscopist mentor from the BCSP acting as their mentor.

If the time outside the BCSP is 6 months or longer, at least the first four colonoscopies (and ideally the first 10) should be performed with a screening colonoscopist mentor. Screening colonoscopists 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.
Accreditation of Screening Colonoscopists
Developed by the JAG Office on behalf of the Bowel Cancer Screening Programme © Royal College of Physicians 2013
9. Bibliography

Reference books


Published papers


**Electronic/Web-based media**

[www.screenerssupport.nhs.uk](http://www.screenerssupport.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.)

[www.practicalcolonoscopy.org.uk/](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
[www.bsg.org.uk/pdf_word_docs/consent.pdf](http://www.bsg.org.uk/pdf_word_docs/consent.pdf)

BSG Guideline on safety and sedation for endoscopic procedures
[www.bsg.org.uk/pdf_word_docs/sedation.doc](http://www.bsg.org.uk/pdf_word_docs/sedation.doc)

BSG Antibiotic prophylaxis in gastrointestinal endoscopy

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

BSG Guideline after the removal of colorectal adenomatous polyps
[www.bsg.org.uk/pdf_word_docs/ccs3.pdf](http://www.bsg.org.uk/pdf_word_docs/ccs3.pdf)
BSG Guideline for the management of inflammatory bowel disease
www.bsg.org.uk/pdf_word_docs/ibd.pdf

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

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

NICE Referral guidelines for suspected cancer
www.nice.org.uk/guidance/index.jsp?action=byID&r=true&o=10968
Appendix 1
NHS BCSP Accreditation Panel

Purpose

The main purposes of the Accreditation Panel are

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

The Accreditation Panel reports to the national office of the NHS Bowel Cancer Screening Programme (BCSP) and has primary responsibility for ensuring that bowel cancer screening is provided by safe, competent, high-quality colonoscopists. The panel is quorate when at least four people are present.

To achieve the objectives outlined in the terms of reference below, the panel membership will include representatives from the JAG, the BSG and the ACP. It will comprise a secretary and four colonoscopists from the BCSP, including an accredited assessor and a training lead. It will be chaired by the education adviser to the National Endoscopy Training Programme.

The panel's work will be informed by input from the bodies and professions it represents, data in candidate applications, the assessment and accreditation processes, assessor and candidate evaluations and external assessor reports.

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

Terms of reference

- To determine, and to advise the NHS BCSP on, strategic direction for the development, recruitment, assessment and accreditation of screening colonoscopists
- To develop and review appropriate criteria for screening colonoscopists
- To devise and maintain an appropriate assessment process
- To advise on the recruitment, induction and training of assessors
- To receive and review applications from, and assessment data about, candidates and to compare these data with agreed criteria for accreditation
- To advise the NHS BCSP about candidates who meet the criteria for accreditation
- To receive and review accredited screening colonoscopists’ annual performance data and advise the NHS BCSP on renewal of accreditation
- To monitor and quality assure the assessment and accreditation process.

These terms of reference will be reviewed annually.

Date of first issue: June 2006
Date of this amendment: July 2011
Date of next review: July 2013
## APPENDIX 2

### 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 grade 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 grade descriptors to inform grading
- To be able to assess candidates fairly with a high degree of reliability.

#### Outline of training workshop

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<td>Welcome and introductions</td>
<td>Brief introductions and previous examining experience</td>
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<td>Preparing to assess: the DOPS and DOPyS</td>
<td>Plenary overview of the form and descriptors</td>
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<td>forms and the grade descriptors</td>
<td>Discussion: potential problems with DOPS</td>
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<td>Putting it into practice: grading a colonoscopy</td>
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<td>Completing the process: discussion and writing feedback</td>
<td>Plenary presentation</td>
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APPENDIX 3

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 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

Choice of case

Please make every effort to ensure that the patients you select

- have fully consented to being involved in the assessment and to the presence of two assessors

- 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)

- 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, the sedatives and analgesics available.

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 45 minutes to complete the entire procedure
- consent should take no more than 5 minutes
- if they are failing to progress, or are judged to be at significant risk of causing a complication, 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 13 and 14 below).

6. 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 colonoscopies.

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. a 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 examiners agree that the patient is in danger of significant harm.
15. Make your assessment independently of the other assessor, 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 assessor. 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 two DOPS (and any DOPyS) assessment forms (one from each assessor, at Appendix 8) and the detailed feedback form to the candidate (one only, at Appendix 12) 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 formally accredited and informed by letter with their confirmed grades and a copy of the detailed feedback form.
Appendix 4
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 will also be expected to prepare and support aspirant screeners for this element of the programme.

Criteria

Mentors will need to be:

- Be fully accredited Screening Colonoscopists
- Meet the BCSP QA standards for Colonoscopy
- Be TCT trained
- Be supported by their Screening Centre Director
- Have attended a BCSA mentorship or DOPyS training day
Appendix 5
Accreditation of Screening Colonoscopists

SAMPLE
APPLICATION FORM
(See overleaf)

Applications must be completed *online only*
Via [www.saas.nhs.uk](http://www.saas.nhs.uk)
Accreditation of Screening Colonoscopists
Developed by the JAG Office on behalf of the Bowel Cancer Screening Programme © Royal College of Physicians 2013
4. Median doses of sedation and analgesics given: (major criteria)
Target median sedation levels ≤5mg midazolam and ≤50mg pethidine or 100μg fentanyl in < 70 years, and ≤2.5mg midazolam and ≤2.5mg pethidine or 50μg fentanyl in > 70 years. If a candidate’s practice is to use a higher opiate dose and a proportionately lower benzodiazepine dose, that will be taken into account and assessed on a case-by-case basis.

<table>
<thead>
<tr>
<th>Age</th>
<th>Midazolam</th>
<th>Pethidine</th>
<th>Fentanyl</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 70</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
</tr>
<tr>
<td>&gt; 70</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
</tr>
</tbody>
</table>

Please provide details of your sedation and analgesic practice if outside of expected levels:

5. Number of failed procedures
   Completion rate: 98.6%  
   (Expected to be 96% or greater)

6. Please upload the following documents
   i) Numbers of incomplete examinations with details of reasons for failure to complete
   ii) All four DOPyS must be non-polydeformities; at least one >10mm and at least one using EMR technique. It is naturally expected that all 4 DOPyS should have an overall score of 3 or 4 (competency).

A1.1.docx
DOPyS L-4.docx

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

7. Documentation of Polyp detection in this 12 month period %: 21.00  
   (major criteria)

Documentation of polyp retrieval rate in this 12 month period %: 10.00  
   (major criteria)
### APPLICATION FORM

7. Complications during your colonoscopies 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>1</td>
<td>0.99</td>
</tr>
<tr>
<td>Significant bleeding (post-polypectomy bleeding requiring transfusion)</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Over-sedation with use of reversal agents</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>Need for unplanned admission</td>
<td>1</td>
<td>0.99</td>
</tr>
<tr>
<td>Other (please indicate)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Pre-accreditation Prep Day: □ Yes □ No (Have you attended a pre-accreditation prep day?)

If you, who ran this day?

<table>
<thead>
<tr>
<th>Dr N Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr T R Keel</td>
</tr>
</tbody>
</table>

The JAG Accreditation Panel have agreed that to be assessed by the same person who has carried out a Pre-Accreditation Preparation who constitute a conflict of interest. Should you attend such an event in the period between submitting an application and attending for assessment you are obliged to provide details of such an assessment by email to JAGoffice@bcp.org.uk.

9. Please indicate if you are familiar with the Olympus ScorpioEndo iMag 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-BCS4)
- □ Never used the imager

The cost of accreditation is met by your Screening Centre. Please give invoice details:

- Name: Mr G Smith
- Designation: Programme Manager
- Address: Salford Royal NHS Foundation Trust
  
  Turfway Hospital
  Turfway
  TQ1 7NH
  
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 JAG 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 6

New screening colonoscopist request form

**REQUEST FOR AN ADDITIONAL SCREENING COLONOSCOPIST**

<table>
<thead>
<tr>
<th>Screening Centre</th>
<th>Population:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Sites:</th>
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</table>

<table>
<thead>
<tr>
<th>Accredited Screening Colonoscopists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>------</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Proposed candidate/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name &amp; email address</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
</tbody>
</table>

**Reason for request (e.g. replacement/surveillance/age extension)**

PLEASE ALSO ATTACH ESTIMATED SCREENING COLONOSCOPY NUMBERS FOR THE FORTHCOMING 12 MONTHS (CAPACITY PLAN)

**Date:**

Requested by: [Clinical Director or Programme Manager]
(email from person making request will suffice)

*From Sept 2013 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 Accreditation of Screening Colonoscopists, JAG Office askas@rcplondon.ac.uk*
Appendix 7
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 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.
### DOPS Assessment form

**Certification of screening colonoscopists**

<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&lt;br&gt;• Satisfactory procedural information&lt;br&gt;• Risk and complications explained&lt;br&gt;• Co-morbidity&lt;br&gt;• Sedation&lt;br&gt;• Opportunity for questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrates respect for patient's views and dignity during the procedure&lt;br&gt;• 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&lt;br&gt;• Gives appropriate dose of analgesia and sedation and ensures adequate oxygenation and monitoring of patient&lt;br&gt;• 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&lt;br&gt;• Performs PR&lt;br&gt;• Maintains luminal view / inserts in luminal direction&lt;br&gt;• Demonstrates awareness of patient’s consciousness and pain during the procedure and takes appropriate action&lt;br&gt;• Uses torque steering and control knobs appropriately&lt;br&gt;• Uses distension, suction and lens washing appropriately&lt;br&gt;• Recognises and logically resolves loop formation&lt;br&gt;• Uses position change and abdominal pressure to aid luminal views&lt;br&gt;• Complete procedure in reasonable time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and therapeutic ability</td>
<td>Adequate mucosal visualisation&lt;br&gt;• Recognises caecal landmarks or incomplete examination&lt;br&gt;• Accurate identification and management of pathology&lt;br&gt;• Uses diathermy and therapeutic techniques appropriately and safely&lt;br&gt;• Recognises and manages complications appropriately</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Case Difficulty**

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

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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 3 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 2s 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>
</tr>
</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>
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<td></td>
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</tbody>
</table>

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Appendix 9
Criteria for Accreditation and Grade Descriptors

To become an accredited screening colonoscopist, 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: colonoscopists 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**

**Grade 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.

**Grade 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.

**Grade 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.

**Grade 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**

**Grade 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.

**Grade 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.

**Grade 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.

**Grade 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**

**Grade 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.

**Grade 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.

**Grade 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.

**Grade 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**

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

**Grade 3** – Adequate mucosal visualisation with only occasional loss or sub-optimal views (unless outwith control of endoscopist, e.g. stool or severe diverticular disease). Faecal pools adequately suctioned. Attempts to retroflex in rectum. Correctly identifies caecal 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.

**Grade 2** – Mucosal views intermittently lost for longer than desirable. Recognises most caecal 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.

**Grade 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 10

## DOPyS form

**DOPyS: Polypectomy Assessment Score Sheet**

<table>
<thead>
<tr>
<th>Generic</th>
<th>Polypt 1</th>
<th>Polypt 2</th>
<th>Polypt 3</th>
<th>Polypt 4</th>
<th>Polypt 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimising view of / access to the polyp:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Attempts to achieve optimal polyp position</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Optimises view by aspiration/injection/wash</td>
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<tr>
<td>3. Determines full extent of lesion (+/- use of adjunctive techniques e.g. bubble breaker, NBI dye spray etc) if appropriate</td>
<td></td>
<td></td>
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<tr>
<td>4. Uses appropriate polypectomy technique (e.g. taking into account site in colon)</td>
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<tr>
<td>5. Adjusts/controls scope position</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6. Checks all polypectomy equipment (forceps, snare, clips, haemoclip) available</td>
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<tr>
<td>7. Checks operator assistant on scope closure prior to introduction into the scope</td>
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<tr>
<td>8. Clear instructions to and utilisation of endoscopy staff</td>
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<tr>
<td>9. Checks diathermy settings are appropriate</td>
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<tr>
<td>10. Photo-documents pre and post polypectomy</td>
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**Staked polyps: Generic, then**

<table>
<thead>
<tr>
<th></th>
<th>Polypt 1</th>
<th>Polypt 2</th>
<th>Polypt 3</th>
<th>Polypt 4</th>
<th>Polypt 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Applies prophylactic haemostatic measures if deemed appropriate</td>
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<tr>
<td>12. Selects appropriate snare size</td>
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<tr>
<td>13. Directs snare accurately over polyp head</td>
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<tr>
<td>14. Correctly selects snare or piecemeal removal depending on size</td>
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<tr>
<td>15. Advances snare further towards stalk as snare closed</td>
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<tr>
<td>16. Places snare at appropriate position on the stalk</td>
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<tr>
<td>17. Mobilises polyp to ensure appropriate amount of tissue is trapped within snare</td>
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<tr>
<td>18. Applies appropriate degree of diathermy</td>
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**Senile lesions / Endoscopic mucosal resections: Generic, then**

<table>
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<tr>
<th></th>
<th>Polypt 1</th>
<th>Polypt 2</th>
<th>Polypt 3</th>
<th>Polypt 4</th>
<th>Polypt 5</th>
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</thead>
<tbody>
<tr>
<td>19. Adequate sub mucosal injection using appropriate injection technique, maintaining views</td>
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<tr>
<td>20. Only proceeds if the lesion lifts adequately</td>
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<tr>
<td>21. Selects appropriate snare size</td>
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<tr>
<td>22. Directs snare accurately over the lesion</td>
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<tr>
<td>23. Correctly selects snare or piecemeal removal depending on size</td>
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<tr>
<td>24. Appropriate positioning of snare over lesion as snare closed</td>
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<tr>
<td>25. Ensures appropriate amount of tissue is trapped within snare</td>
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<tr>
<td>26. Tenis lesion gently away from the mucosa</td>
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<td>27. Uses cold snare technique or applies appropriate diathermy, as applicable</td>
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<tr>
<td>28. Ensures adequate haemostasis prior to further resection</td>
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**Post polypectomy**

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<th>Polypt 3</th>
<th>Polypt 4</th>
<th>Polypt 5</th>
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</thead>
<tbody>
<tr>
<td>29. Examines remnant stalk/polyp base</td>
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<tr>
<td>30. Identifies and appropriately treats residual polyp</td>
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<tr>
<td>31. Identifies bleeding and performs adequate endoscopic haemostasis if appropriate</td>
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<tr>
<td>32. Reviews, or attempts retrieval of polyp</td>
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<tr>
<td>33. Checks for retrieval of polyp</td>
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<tr>
<td>34. Places tattoo competently, where appropriate</td>
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**Polypt size:** L/SL/SL/GC/RECUM

**Overall Competency at Polypectomy:** 4/5/4/1

**Comments:**

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Appendix 11
Grade descriptors for DOPyS

DOPyS descriptors – generic

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.

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.

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 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.

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

11. Applies prophylactic haemostatic measures (e.g. endo-loop, clips, if deemed 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 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 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.
DOPyS Descriptors - 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.
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.
28. Does not necessarily ensure adequate haemostasis prior to further resection.

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.
### 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 12
DOPS feedback form

Detailed DOPS feedback form for accreditation of screening endoscopists

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

Candidate’s Name
Date of assessment

Relative strengths

1.

2.

3.

Areas for focus or what candidate may do differently next time

1.

2.

3.

Suggested development needs, areas for focus at trust/additional comments:

Recommendation due date and review process

12 months
6 months
3 months
Immediate

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Appendix 13
Continued Accreditation

Criteria

- Intends to undertake a minimum of 150 screening colonoscopies per year.
- Maintains a level of complications over a prolonged period that remains below the national average as outlined by the latest national/BCSP audit data, as defined in Bowles et al. (2004).
- Quality monitoring data from the bowel cancer screening IT system (BCSS) confirms that the screening colonoscopist continues to meet the application criteria.

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

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

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