ACCREDITATION OF SCREENING COLONOSCOPISTS

NHS BCSP Implementation Guide No 3
Version 10

June 2010

Document purpose
Produced on behalf of the NHS Bowel Cancer Screening Programme to provide a framework for the accreditation of screening colonoscopists

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Target audience
Prospective candidates for accreditation; BCSP accreditation assessors; screening centres; QARCs
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1. INTRODUCTION

The NHS Bowel Cancer Screening Programme (NHS BCSP) has been implemented over a three year period and has recruited expert colonoscopists to carry out the 30,000 additional colonoscopies required to fulfil its aims. 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.

There are several advantages to this accreditation process, both to 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 NHS Bowel Cancer Screening Programme certificate, is shown in Figure 1.

2. ACCREDITATION PANEL

The Accreditation Panel advises the NHS BCSP 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.

4. APPLICATIONS FOR SCREENING ACCREDITATION

Invitations to apply for screening accreditation are subject to the following criteria. A sample application form is shown in Appendix 4.

i. Applicants must be attached to a screening centre. The screening centre Director/Programme Manager should seek approval for the proposed candidate from the NHS Cancer Screening Programmes national office. Once approved an account will need to be created for the candidate to apply on line at www.saas.nhs.uk. No paper applications will be accepted.
ii. Although preference will be given to applicants carrying out more than 200 examinations per year, a threshold level of 150 examinations is required in the 12 months before accreditation. Documentation must be supplied, although a proportion of these examinations are expected to be undertaken by SpRs, by others under the supervision of the applicant, or in private practice. Applicants must also have a minimum lifetime colonoscopy experience of 1000 examinations.

iii. Applicants 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 obstructing lesions or faecal obstruction will count as failures. 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.

iv. Applications will be accepted on the understanding that, if successful, the applicant will aim to begin screening colonoscopies within six months of accreditation.

v. Applicants should be aware that their application confirms their intention to undertake 150 or more screening colonoscopies each year and to submit quality monitoring data at least annually.

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

vii. Applicants planning to attend a pre-accreditation preparation day should do so at least six weeks prior to the assessment date. (On the cancellation of assessments see section 5.1.)

viii. Assessment by the person who carried out the pre-accreditation preparation would constitute a conflict of interest and in such cases applicants should alert the secretary of the Accreditation Panel.

5. ACCREDITATION ASSESSMENT PROCESS

5.1 Acceptance of applications

Applications will be screened by the secretary of the Accreditation Panel and applicants who meet the six criteria outlined above will be invited for further assessment at a centre. Any application that fails to meet the criteria will be referred back to the candidate. In ambiguous cases, the application will be referred to the Panel chair for review by chair’s action or the full panel. Once an assessment date has been confirmed withdrawal at less than six weeks’ notice will render the candidate liable to the assessment fee quoted at the time of booking.
5.2 **Written assessment**
The assessment includes a one hour multiple choice questionnaire (MCQ) of 30 questions based largely on lesion recognition and management. A list of topics is included in Appendix 5. A reading list for candidates who wish to prepare for the written assessment appears in the Bibliography.

5.3 **Direct observation of procedural skills**
The written assessment will be followed by a direct observation of procedural skills (DOPS) examination over two consecutive cases. The DOPS will be supervised by 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 unused to 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. 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 DOPS assessment will be conducted according to defined criteria. The assessors will determine whether the candidate

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

To guide assessors, the DOPS assessment form is divided into four domains: assessment, consent and communication; safety and sedation; endoscopic skills; diagnostic and therapeutic ability. An outline of each domain appears on the assessment form at Appendix 6. 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. 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. Note that 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 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 (<5mm) 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.

5.4 Feedback to candidates
At the end of the assessment the assessors will complete the DOPS assessment form (Appendix 6). Using the form at Appendix 8 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 Accreditation Panel for formal ratification. Candidates should be advised that DOPS scores will be scrutinised before the outcome of the assessment is formally confirmed by the chair of the Accreditation Panel. Assessors usually recommend either that the Panel accredit the candidate or, occasionally, that she or he undergo a period of further endoscopic professional development followed by a second assessment with two fresh assessors.

5.5 Accreditation Panel
Once all elements of the assessment are complete the results will be assembled by the Panel secretary and reviewed by the Panel chair. If all the criteria are met the chair will recommend to the NHS BCSP that the candidate be formally accredited. The national office of the NHS BCSP will inform the candidate by letter and issue a certificate of accreditation. If the criteria are not fully met the Panel will make recommendations to the BCSP concerning feedback to the candidate and further development and training needs. Candidates may appeal against the assessment process but not the judgement of the assessors or the Panel.

5.6 Candidates not meeting criteria
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 fresh assessors. If they fail to meet the criteria at that second attempt they cannot reapply until 12 months after the date of the first.
6. CRITERIA FOR CONTINUED ACCREDITATION

The status of accredited screening colonoscopists will be reviewed by the Accreditation Panel on an annual basis. Accreditation will be renewed if the applicant

- 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 defined in Bowles et al (2004)

Quality monitoring data from the bowel cancer screening IT system (BCSS) will be used to confirm that the screening colonoscopist continues to meet the application criteria. Appendix 9 outlines actions that may be taken if those criteria are not met.

7. ASSESSMENT CENTRES AND ENQUIRIES

Assessment centres are located at St Mark’s Hospital (London), St George’s Hospital (London), New Cross Hospital (Wolverhampton), Northern General Hospital (Sheffield) and Torbay Hospital (Torquay). 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. An assessment coordinator manages the application process, organises the panel that will evaluate applications, liaises with assessors, and matches candidates to exam dates. The accreditation process is managed and quality assured by the Accreditation Panel.

Queries about the accreditation process should be addressed to Professor Roger Barton, Chair, Accreditation Panel (Roger.barton@northumbria-healthcare.nhs.uk), 0191 293 2576 or Mrs Lynn Coleman, Assistant Director, NHS Cancer Screening Programmes, (lynn.coleman@cancerscreening.nhs.uk), 0114 221 1086.
Figure 1  Accreditation process

Collection of documentation by applicant

Confirmed by endoscopy manager and consultant endoscopist/clinical director

Approval of application confirmed by NHS CSP national office
Account established for applicant at www.saas.nhs.uk

Application for accreditation (including CV) and assessment booking completed online

Assessment
- MCQ
- DOPS
- feedback
- Accreditation Panel review of results
- report to BCSP

Meets criteria
- accredited for screening
- certificate issued
- continued collection of quality indicators

Criteria not met
- additional training and support
- continued collection of quality indicators

Appeal
- review of process by panel

Appeal upheld
Repeat assessment at second centre

Re-submission and re-assessment

Appeal unsuccessful
BIBLIOGRAPHY

Reference books


Published papers


Electronic/Web based media

http://www.screenersupport.nhs.uk
This website contains endoscopic images, video clips, web pages, the curriculum for the revised MCQ and a discussion forum. (Registration required).

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

Colonoscopy: the DVD

Polypectomy and Electrosurgery Techniques (VHS/CDROM)

Dysplasia in UC (DVD)
Arebi N, Suzuki N, Saunders BP. St. Mark’s Hospital, 2005.

Web based professional guidelines (Accessed 29 June 2010)

BSG Guideline for informed consent for endoscopic procedures

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

BSG Antibiotic prophylaxis in gastrointestinal endoscopy

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

BSG Guideline after the removal of colorectal adenomatous polyps

BSG Guideline for the management of inflammatory bowel disease

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.

BSG Guideline for screening and surveillance of asymptomatic colorectal cancer in patients with IBD.

NICE Referral guidelines for suspected cancer
APPENDIX 1

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 colonoscopy quality assurance group 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

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

These terms of reference will be reviewed annually.

Date of first issue: June 2006
Date of amendment: June 2010
Date of next review: June 2011
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 DOPS assessment

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

Outline of training workshop

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Activity</th>
<th>Lead facilitator</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>09.30</td>
<td>Registration and coffee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.00</td>
<td>Welcome and introductions Overview of the day</td>
<td>Brief introductions and previous examining experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.15</td>
<td>Preparing to assess: the DOPS form and the grade descriptors</td>
<td>Plenary overview of the form and descriptors Discussion: potential problems with DOPS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.00</td>
<td>Putting it into practice: grading a colonoscopy</td>
<td>Video</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.30</td>
<td>Completing the process: discussion and writing feedback</td>
<td>Plenary presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.00</td>
<td>Grading colonoscopies</td>
<td>Practical grading of real-time procedures and pair discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.00</td>
<td>Lunch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.45</td>
<td>Grading colonoscopies</td>
<td>Practical grading of real-time procedures and pair discussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.45</td>
<td>Pulling it all together</td>
<td>Plenary feedback around practical experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.00</td>
<td>Close</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 is marked positively; no marks are subtracted for incorrect answers. Whether they tick ‘Don’t know’ or get the answer wrong the outcome is the same: no mark scored.

DOPS

Choice of case

Please make every effort to ensure that the patients you select

- have fully consented to being involved in the assessment and to the presence of two assessors
- are unlikely to be particularly challenging for the candidates: eg have not previously undergone a very difficult, painful or failed procedure; 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: eg 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 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 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 (eg 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 – eg a patient may have no pathology or require no therapy – a Grade 3 or 4 may still be awarded in that domain.

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

11. 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.

12. 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.

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

14. 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.)

15. 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.

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

17. 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 assessment forms (one from each assessor, at Appendix 6) and the detailed feedback form to the candidate (one only, at Appendix 7) must then be passed to the Accreditation Panel. The Panel will then consider the information and evidence and, if appropriate, make a formal recommendation to the NHS BCSP for accreditation. (For candidates who have not yet met the criteria for accreditation, see section 5.6.) The Panel secretary will issue candidates with their confirmed grades and a copy of the detailed feedback form.
APPENDIX 4

ACCREDITATION OF SCREENING COLONOSCOPISTS

SAMPLE
APPLICATION FORM
(see overleaf)

Applications must be completed online only via Joint Advisory Group on GI Endoscopy (www.saas.nhs.uk).

Please note that paper applications will not be accepted.
APPLICATION FORM

4. Median doses of sedation and analgesics given: (major criteria)
   Target median sedation levels 25mg midazolam and 250mg pethidine in < 70 years, and 2.5mg midazolam and 250mg pethidine in > 70 years.

   < 70
   - 15.00 / 2.50 Midazolam
   - 10.00 / 5.00 Pethidine
   - 10.00 / 5.00 Fentanyl
   - 10.00 / 5.00 Buscopan

   > 70

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

5. Completion rate:
   (major criteria)
   95.00 * On intention to treat basis. (Expected to be 90% or greater)

   Please upload details of incomplete examinations as an attachment (word, excel or pdf):

   *Incomplete examinations.docx

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

6. Polyp detection %:
   (major criteria)
   25.00 * (Documentation of detection and removal rate in this 12 month period, expected to be greater than 20%)

   Polyp retrieval %:
   (major criteria)
   85.00 *

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### 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>Vascular accident</td>
<td>5</td>
<td>3.33</td>
</tr>
<tr>
<td>Significant bleeding (post-polypectomy bleeding requiring transfusion)</td>
<td>9</td>
<td>5.50</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>0.59</td>
</tr>
<tr>
<td>Other (state)</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?
   - Dr A H Other
   - Mr T K Niner

The BCSP 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 accreditation you are subject to provide details of such attendance by email to indica.ascd@nhs.net

9. Please indicate if you are familiar with the Olympus Scoposlide Imager equipment (also known as the magnetic imaging):
   - [ ] 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-BCSIA)
   - [ ] 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:** South Devon Bowel Cancer Screening Centre
  Torquay Hospitals
  Torquay
  TQ2 7HN

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.
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. Whether you tick ‘Don’t know’ or get the answer wrong the outcome is the same: no mark scored.

Topics covered in multiple choice questions
- Patient consent
- Safe sedation
- Colonic anatomy and attachments relevant to 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 colleagues to observe you and give you feedback based on the DOPS form. 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 (<5mm) 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.
### APPENDIX 6

**DOPS Assessment Form**

Certification of Screening Colonoscopists

<table>
<thead>
<tr>
<th>Candidate</th>
<th>Assessor</th>
</tr>
</thead>
<tbody>
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<table>
<thead>
<tr>
<th>Assessment Centre</th>
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<table>
<thead>
<tr>
<th>Date (DD/MM/YYYY) Case Number</th>
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</table>

#### Scale and Criteria Key

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

#### Headline Criteria

**Assessment, consent, communication**

- Obtains informed consent using a structured approach
  - Satisfactory procedural information
  - Risk and complications explained
  - Co-morbidity
  - Sedation
  - Opportunity for questions

- Demonstrates respect for patient's views and dignity during the procedure

- Communicates clearly with patient, including outcome of procedure with appropriate management and follow up plan.

**Safety and sedation**

- Safe and secure IV access
- Gives appropriate dose of anaesthesia and sedation and ensures adequate oxygenation and monitoring of patient
- Demonstrates good communication with the nursing staff, including dosages and vital signs

**Endoscopic skills during insertion and procedure**

- Checks endoscope function before intubation
- Performs PR
- Maintains lumen view / inserts in luminal direction

- Demonstrates awareness of patient’s consciousness and pain during the procedure and takes appropriate action

- Uses torque steering and control knobs appropriately

- Uses distension, suction and lens washing appropriately

- Recognises and logically resolves loop formation

- Uses position change and abdominal pressure to aid luminal views

- Completes procedure in reasonable time

**Diagnostic and therapeutic ability**

- Adequate mucosal visualisation

- Recognises caecal landmarks or incomplete examination

- Accurate identification and management of pathology

- Uses diathermy and therapeutic techniques appropriately and safely

- Recognises and manages complications appropriately

#### Case Difficulty

<table>
<thead>
<tr>
<th>Extremely easy</th>
<th>Fairly easy</th>
<th>Average</th>
<th>Fairly difficult</th>
<th>Very challenging</th>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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**Screening Colonoscopist DOPS Assessment Form**

**Last updated 05 November 2009**

**Author:** JAG Central Office

For further information, please contact the JAG office: thejag@jag.org.uk | 020 3070 1629 | www.jag.org.uk
Assessor Declaration

Certification of Screening Colonoscopists

To become an accredited screening colonoscopist, 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 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 colonoscopist is ready to become an independent colonoscopist?

Please check one of the two boxes below.

☐ The candidate should be certified for screening colonoscopy

☐ The candidate should not yet be certified for screening colonoscopy

ASSESSOR SIGN OFF

We certify that

☐ Meets the DOPS criteria outlined on page one

☐ Meets the minimum DOPS standards above

Assessor 1

GMC number

Assessor 2

GMC number
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

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 outwith control of endoscopist: eg stool, severe diverticular disease). Faecal pools adequately suctioned. Attempts to retroflex in rectum. Correctly identifies caecal landmarks or incomplete examination. Accurately identifies pathology and manages 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 caecal landmarks present or eventually identifies an incomplete examination. Most pathology identified with occasional missed or mis-identified lesions. Just acceptable use of diathermy and therapeutic tools with some sub-optimal use. 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

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

Candidate’s name ................................. Date of assessment ............................

Relative strengths
1.

2.

3.

Areas to focus on, or what candidate might do differently next time
1.

2.

3.

Suggested development needs, areas to focus on at base Trust, or additional comments


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 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>
</tr>
<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>
</tr>
<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>
</tr>
<tr>
<td>No evidence submitted</td>
<td>Suspend accreditation until evidence reviewed</td>
<td>Submission of evidence within 28 days</td>
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