

## QA of Individuals Working Group

### Introduction

#### From the QA of Working Group for Individuals Chair

Welcome to newsletter 3 of the JAG Quality Assurance Working Group for Individual Endoscopists. As many of you will know, this Working Group has been specifically constituted by the JAG Committee to make recommendations about how, in future, individual endoscopists will measure their own routine practice against those of their peers and against peer-agreed standards.

This Working Group is one of three such groups set up by the JAG Committee and I have been appointed as the interim chairman of this Working Group. The other two Working Groups are concerned with Quality Assurance of Endoscopy Units and Quality Assurance of Training.

#### Revalidation of Endoscopists – Knowledge Base

It was envisaged that the revalidation cycle would be 5 years. E-modules under the e-Learning for Health project were currently being considered for the knowledge element of endoscopy revalidation. The Working Group have agreed that a pass indicator turning a specific module 'green' would be created when the user has satisfactorily completed each module. Each module can be undertaken as many times as it takes to achieve a 'green' outcome. All required modules would need to be completed to ensure revalidation. The frequency of the knowledge-based revalidation has not been agreed. Although the Working Group understands that the e-Learning for Health project has been suspended indefinitely it seems likely that that this project will ultimately survive in a much slimmed down but workable form.

#### Multisource Feedback

Multi Source Feedback (MSF) is a mandatory requirement for NHS Trusts. The Working Group considered that MSF for endoscopists would therefore have to be part of this wider process. Although there remain concerns about the fairness, effectiveness and validity of MSF, the Group recognise that there is no choice other than to be part of the mandatory process. To give endoscopic input into MSF, it is suggested that MSF returns include at least one form from an endoscopy assistant and also at least one from an internal peer endoscopist.

#### Skills

Assessment of endoscopy skills has been and will continue to be the most sensitive area in the revalidation debate. Whilst the Working Group have agreed that the DOPS process was the best way of assessing skills, there would be no requirement for most endoscopists to undergo a mandatory DOPS assessment on a regular basis. Furthermore, such DOPS assessments as did occur would be formative.

The suggested format is that endoscopists will be required to keep a continuous record of certain key performance indicators (see below). Providing that the average scores of these indicators fall within accepted limits, no further mandatory process would be required. If an endoscopist's indicators remained consistently below the accepted standards – or if there are other reasons for concern about an endoscopist's performance – a formative DOPS would then become mandatory as part of a (yet to be agreed) remedial process.

Aside from this process, we would encourage all endoscopists within a Unit to submit themselves voluntarily to peer review on a regular basis e.g. one list per year. We would envisage this as a

(usually) internal process involving all endoscopists and undertaken in such a way as to be non threatening and in particular non time consuming.

## **Register of Endoscopists**

The question of a register of endoscopists has been discussed at the JAG Executive Committee. Although there would be many advantages to maintaining an active register of GI endoscopists, this would be a considerable administrative task with major costs involved so there are no immediate plans for this.

## **Revalidation of Upper GI Endoscopists in Primary Care**

Dr Andrew Summers, Primary Care Representative on the Working Group, presented a paper on revalidation of Upper GI Endoscopists. Many primary care endoscopists work in relative isolation in community settings. Following discussion, it was agreed that the standards set for all upper GI endoscopists should be the same in all settings. It was after this discussion that the chairman reminded the Group that the revalidation process was not specifically structured to pick out bad doctors; in contrast, it was set up to highlight any areas of less than optimal practice which could then be improved.

## **Key Performance Indicators for Revalidating Endoscopists**

There has been some preliminary discussion about these KPI's, referred to in the Skills Section (above).

### **General Points**

It is agreed that there should be no more than three or four KPI's assessed continuously per year for each of the 4 main endoscopic groupings (the fourth being EUS). Ideally, these would map where possible to the Global Rating Scale (GRS). Many endoscopy reporting systems (such as Unisoft) were already aware of the data that needed to be collected for KPI's and Prof. John Williams' information group was currently compiling a common minimum dataset for all endoscopy records systems

### **Sedation**

The current NPSA-advised sedation levels were specifically formulated for colonoscopy and did not apply to either Upper GI endoscopy or to ERCP. The Working Group have advised that it is reasonable to apply the same standard for midazolam usage to Upper GI endoscopy as for colonoscopy ie. average doses of < 5mg for age under 70 and <2.5mg for age over 70. This would then become a KPI and an auditable outcome for these 2 procedures.

### **Patient Comfort Scores**

There is a need to universalise the patient comfort scoring system as a number of different scales are currently used. It is recommended that the 4 point Leeds Comfort score (0-3) be used as this is widely used for the GRS returns.

Using this comfort score rating scale, it is advised that >70% of patients endoscoped by an individual endoscopist should have a comfort score in the 0-1 range.

### **Flumazenil Use**

Data on flumazenil usage are already collected as part of the GRS returns. The Group have decided not to use this as a KPI firstly to avoid duplication and secondly because there was a risk that, as a KPI for revalidating an individual endoscopist, it may not actually be given even when clinically needed.

### **Numbers**

The issue of numbers of procedures remains controversial. The Group felt that, for all the faults and caveats associated with recording numbers of procedures, endoscopists do nevertheless require guidance on 'reasonable' numbers accepting that there is no hard evidence directly

correlating continuing competence with numbers of procedures. However, without these guideline numbers, endoscopists have no benchmark against which to compare their practice. Similarly, numbers of procedures provide some guidance for appraisers of endoscopists. The Group have decided that endoscopy numbers should be averaged over two to three years for Upper GI endoscopy and non-BCSP colonoscopy but should be absolute yearly numbers for ERCP and EUS endoscopists.

### **Therapeutic Upper GI endoscopy**

The Group felt that there were insufficient data to devise meaningful KPI's for the wide variety of techniques carried out under this broad heading. This area will be revisited at some time in the future.

### **KPIs for Specific Endoscopic Procedures**

The Group have agreed the following KPI's, subject to the approval of the full JAG Committee:-

#### **Upper GI (diagnostic)**

>100 examinations per year for each endoscopist - average

Failed intubation rate <5%

Average midazolam sedation levels <70 years at 5mg and >70 years at 2.5mg audited

Patient Comfort Score >70% of patients scoring 0-1

(Flumazenil usage to be audited)

#### **ERCP**

>75 procedures per year for each endoscopist - minimum

90% deep cannulation of the desired duct - ITT

<5% Pancreatitis rate (defined as requiring or prolonging admission)

Patient Comfort Scores - >70% of patients scoring 0-1

30 day procedure-related mortality - auditable outcome (no standard)

(Antibiotics prescribed in >90 % of cases of failed biliary decompressions.)

Decompression of obstructed ducts within a specified time period of failed biliary access was discussed as a potential KPI but this was thought to be more a reflection on the competence of the whole service rather than the individual endoscopist.

#### **EUS**

>75 procedures per year per endoscopist - minimum

FNA in >90% where lesion identified

Cyst fluid analysis for CEA/amylase/cytology in >85% where cysts imaged

Antibiotics in all patients post FNA

Using cyst analysis as a KPI remains highly controversial given the original use of EUS for staging malignancy. This has been referred to BSGE for further discussion.

### **Colonoscopy (non-BCSP)**

>100 colonoscopies per year per endoscopist – average

Caecal intubation rate of 90% ITT – photographic evidence required (TI, appendix or i/c valve)

Average Midazolam sedation levels <70 years at 5mg and >70 years at 2.5mg audited

Patient Comfort Score >70% of patients scoring 0-1

It is intended to merge the KPI's for both BCSP colonoscopists and non-BCSP colonoscopists in the near future.

The use of other colonoscopy-related measures remains controversial. Some of these indicators have been in use either as part of the GRS or part of QA of the national Bowel Cancer Screening Programme. They include:-

- colonoscopy withdrawal time (standard >6 mins)
- adenoma detection rate
- adenoma retrieval rate.
- tattooing of polyps and cancers
- use of dye-spraying in IBD surveillance

There are difficulties in the use of all of these as KPI's as the performance depends crucially either on the population of patients being endoscoped and/or on locally decided protocols. Also, some doubt has been expressed regarding the validity of using colonoscopy withdrawal time as a quality indicator. For the present time therefore, the above indicators are not part of the KPI's for non-BCSP colonoscopists.

Jonathan Green – September 2010