Royal College of Physicians | JAG Joint Advisory Group on GI Endoscopy

A framework for managing underperformance and supporting endoscopists – a JAG perspective

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Introduction

Managing underperformance in endoscopists can be challenging for service leads and the practitioner. With the roll-out of the National Endoscopy Database (NED),[1] services have unprecedented access to the performance data of endoscopists, including real-time benchmarking against national quality standards. Inevitably, there will be instances where performance falls below the minimum standards considered acceptable for patient care (ie underperformance). An established framework exists within the English Bowel Cancer Screening Programme (BCSP) to support screening practitioners in difficulty,[2] but a similar pathway is currently lacking outside the context of BCSP, where governance is driven by individual units.

This JAG guidance provides endoscopists and service leads with a UK-focused framework (figure 1) for managing suspected underperformance, with reference to existing BCSP protocols and the recent expert opinion by Rees et al on the identification and management of underperformance in endoscopy.[3]

Methods of identifying underperformance

Underperformance in endoscopy can be identified through a variety of methods (table 1). Most cases will be detected from electronic audits, eg endoscopy reporting systems or NED. Underperformance may also be directly reported by others (patients, colleagues including peers and allied endoscopy staff), indirectly from governance processes (eg complications), or self-reported.

What to do in cases of underperformance

Although endoscopy governance is the responsibility of all involved professionals, each unit should have a named unit lead with overall responsibility for reviewing performance data. Review of underperformance should be shared with other members of the leadership team, including nursing, training and governance leads and with individual endoscopists. The review should be recorded anonymously within the minutes of the appropriate local governance meeting, eg endoscopy user group (EUG) and be made a regular agenda item.

Identifying issues

The root cause of underperformance needs to be explored fully. These can be broadly categorised into technical, behavioural, health and extrinsic issues (table 1). Behavioural issues may occur due to lapses in professionalism or failure to exercise non-technical skills. Extrinsic issues are those beyond the control of the endoscopist, eg patient case mix, list pressures or equipment. The process should start with a confidential meeting with the endoscopist to discuss their data, to ensure accuracy and validity and to discuss any extenuating or underlying circumstances. This should be conducted in a non-judgmental and empathetic manner, considering the likely stress the endoscopist will feel.

Working through identified issues / providing support

Managing underperformance depends on the underlying cause (table 1) and the potential detriment to patient care. If underperformance has been clearly identified, a personalised action plan (as suggested in figure 2) should be completed. This should include the documentation of measurable objectives and appropriate timescales for performance review, as agreed by both the clinical lead and the endoscopist (figure 1). The service should be receptive to the needs of not only the endoscopist, but also for the clinical lead in the supervisor role, who in many cases, may be a close colleague. Engagement with this process is important to aid re-evaluation, especially if underperformance persists after a review interval. At this point, there needs to be careful consideration of further training for technical issues or other additional support, if behavioural or non-technical issues are apparent. Depending on the stratification of risk (low, moderate or high), this may require reassessment with objective competency assessment tools, eg DOPS, either by local or external assessors (table 1).

Governance process and accreditation

Good governance and successful management of underperformance are key to a successful endoscopy service and are recognised in the JAG accreditation process. Services are measured though the GRS (global rating scale) and supporting evidence is examined at both annual review of accredited services and during site assessments every 5 years. A key piece of evidence is the regular (6-monthly) feedback of endoscopist performance and recognition of the process within EUG meetings.

The governance process for managing underperformance should be agreed by service users. Each unit should have access to a reference framework for identifying and managing underperformance. Knowledge of this policy should be incorporated into the induction process of new endoscopists to any unit.

Service considerations

Whilst underperformance of an individual is recognised as a possibility and the processes outlined above are useful to address it, endoscopy services should always prioritise patient safety. If the potential for harm is significant, the service should evaluate whether it is appropriate for an endoscopist to perform independent (unsupervised) endoscopy, whilst subjected to interim training measures. In some cases, individuals with low volume annual numbers have elected to cease endoscopy practice (eg colonoscopy/ERCP). Individuals should consider their data in comparison to the annual procedural numbers recommended in British Society of Gastroenterology (BSG) guidelines.

The management of underperformance also falls under national patient safety initiatives such as the JAG Improving Safety and Reducing Error in Endoscopy (ISREE), Getting it Right First Time (GiRFT) and the NHS Patient Safety Strategy. The NHS Improvement 'Just Culture Guide' supports '*consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents*'. [4-7] Services are encouraged to participate in continuous quality improvement to deliver a high-quality service. The BSG has recognised this with the Endoscopy Quality Improvement Programme (EQIP).[8]

Conversely, data from performance reviews could also be used to identify high performers as potential trainers or mentors to provide coaching and to share good practice.

Conclusion

Underperformance in endoscopy should be identified and managed using a supportive framework embedded within the governance process of an endoscopy unit. Data from colonoscopy show that a significant proportion of newly-certified endoscopists exhibit a drop in performance ("DIP") during newly-independent practice.[9] It is recognised that more needs to be done to support both newly-certified and longstanding endoscopists. The updated JAG certification guidelines will contain a section on post-certification support and mentorship. The principles of mentoring and coaching for managing underperformance are probably as useful for the true expert.[10] Fostering a learning and sharing environment for safety and quality, as envisaged within the ISREE initiative, and providing support for endoscopists when needed, are positive steps for delivering a high-quality endoscopy service.

Tables and figures

Table 1: Framework for identifying and managing underperformance in endoscopy.

Issue	Identifying underperformance	Managing underperformance

Endoscopic (technical) skills	• National data collection (ERS, BCS, NED)
	• Local expectation to audit against KPIs as part of GRS
	• 'Good Medical Practice' placing responsibility on the individual to self-audit and use CPD to ensure personal development as part of PDP
	• Endoscopy governance
	• Self-reporting
		• Verify issue and communicate concerns.
		• Risk stratification (based on severity and chronicity of underperformance)
		  • Low: Inform and re-evaluate
		  • Moderate: Mentorship, internal support, reducing list size and not allowing the individual to train others so that they focus on their own performance. PDP to identify learning needs and agree support model with their appraiser or mentor
		  • Severe: Peer-review of technical skills; review privileges for independent endoscopy.
		• Mentorship in screening (with a cohort trained through SAAS).
		• Attendance at upskilling courses; formal evaluation using DOPS assessments.

Health	• Self-reporting and appraisal as routes to identify concerns	• Occupational health, eg ergonomics review / engagement with GP / use of external resources eg NHS Practitioner Health Programme. • For those with lack of insight, this would sit under the medical director's office who would provide support, or with a director of nursing.

Behaviours	• Peer-feedback as part of revalidation for doctors and nurses
	• Individual concerns raised by staff members or patients
	• Endoscopy governance
	• Self-reporting
		• Would sit within the professional conduct framework, hence could be managed:
		  • locally by a QA lead
		  • within a directorate or division to provide externality and appropriately trained individuals to support
		  • medical director's office through the Maintaining High Professional Standards Framework, depending on severity, chronicity.
		• Core to the approach is appropriate data collection (MSF / 360), supported discussions and reflection, simulation based training and access to external programmes, with the use of a formal process of conduct only in very extreme cases, with a plan for remediation.
		• Non-technical skills training.

Extrinsic	• GRS as a measure of whole unit performance and standard setting	• Local and GRS driven systems to define the model of a good unit and support / advise on managing this. • JETS Workforce programme to upskill endoscopy assistants and improve unit quality.

Abbreviations: ERS - endoscopy reporting system, NED - National Endoscopy Database, MSF - Multisource feedback, GRS – global rating scale, QA – quality assurance, SAAS - Screening Assessment Accreditation System, BCS – Bowel Cancer Screening, CPD – Continuing Professional Development, KPI – key performance indicator, DOPS - direct observation of procedural skills, PDP – personal development plan

Figure 1: JAG framework for managing endoscopists in difficulty.

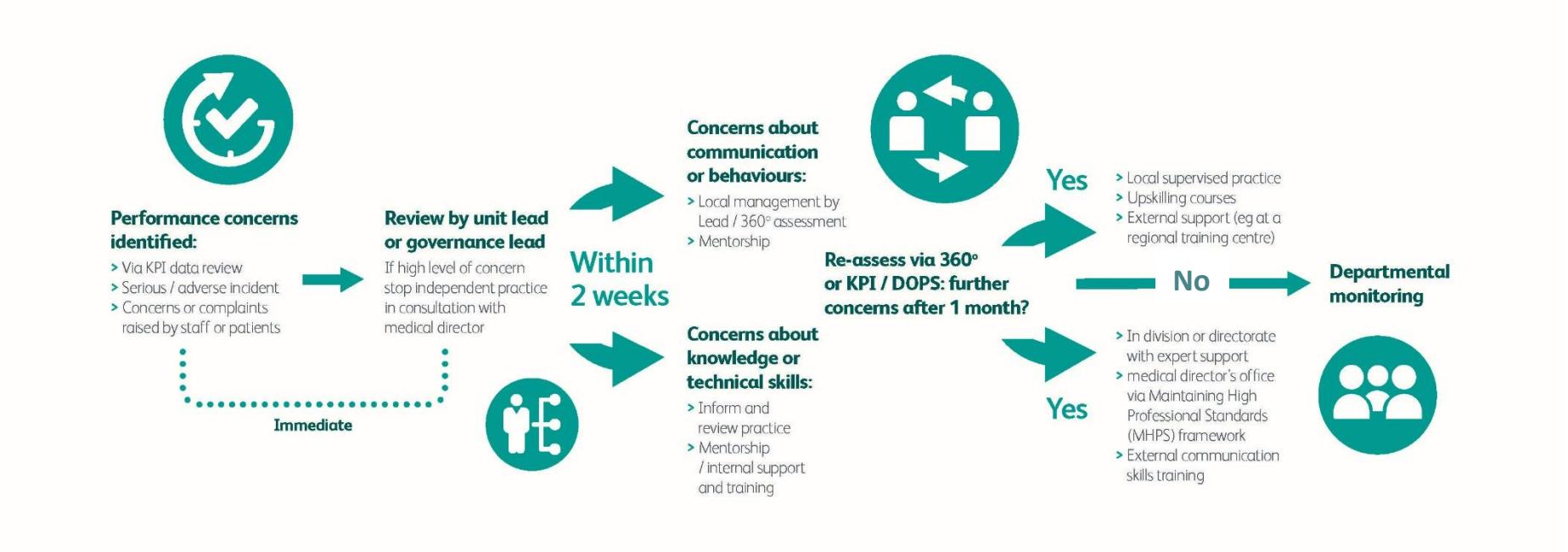

Figure 2: Pro forma recommendations for documenting action plans for managing underperformance in endoscopy.

Date of meeting				
Clinical lead			GMC/NMC no	
Endoscopist			GMC/NMC no	
Background	OGD	Flexible sig.	Colonoscopy	Other
Annual numbers				
Years independent				
Date of last appraisal				
Name of clinical appraiser				
KPI data review		Data period		
Summary of data				
Discussion of Data				
Additional factors (extrinsic, health)				
Risk stratification	Low	Moderate	Severe	
Action plan				
Review of action plan			Date	
Discussion at annual appraisal required Yes/No			Date	
Clinical lead signature				
Endoscopist signature				

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