

**Mentoring and Quality Assurance of
screening endoscopists within the
NHS Bowel Cancer Screening
Programme**

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About the NHS Cancer Screening Programmes

The national office of the NHS Cancer Screening Programmes is operated by Public Health England. Its role is to provide national management, coordination, and quality assurance of the three cancer screening programmes for breast, cervical, and bowel cancer.

About Public Health England

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- The JAG/NHSBCSP Accreditation Panel
- The NHSBCSP Endoscopy QA Group
- The Joint Advisory Group for Gastrointestinal Endoscopy (JAG)
- NHSBCSP screening endoscopists

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Executive summary

Endoscopists commencing practice within the NHSBCSP (including bowel scope screening) allow their practice to be closely scrutinised and monitored. This 'step-up' in practice is significant for many and support from colleagues is often sought.

Within the screening programme in England there have been occasional reports of screening endoscopists with complication rates that are higher than expected. Regional Quality Assurance Reference Centre (QARC) teams have investigated the circumstances and, where appropriate, they have recommended further training and, in some cases, reaccreditation.

To date there have been no clearly defined criteria for the supplementary training and reaccreditation of individuals who fail to meet agreed Quality Assurance (QA) standards. This document is intended to be the first step towards a well-defined, open, and fair process that can be applied to all individuals who find themselves in this situation. Since each case is unique, it is not possible to provide detailed guidance covering every scenario; instead a set of generic principles and basic lines of responsibility are identified.

In particular, the document:

- Defines a screening endoscopist in difficulty
- Outlines the pivotal role played by a mentor in supporting a screening endoscopist in difficulty and the characteristics required of mentors within the NHSBCSP
- Describes the range of issues encountered and triggers for further intervention
- Explains the principles to be adopted when dealing with a screening endoscopist in difficulty
- Describes formal and informal approaches to solving problems of knowledge, skill, and behaviour
- Provides basic guidance for the reassessment process

1. Introduction

1.1 Context

Endoscopists stepping up to practice within the NHSBCSP (including bowel scope screening) allow their practice to be closely scrutinised and monitored. This 'step-up' in practice is significant for many and support from colleagues is often sought.

The bowel cancer screening accreditation process for England has been in place since the beginning of the NHS Bowel Cancer Screening Programme (NHSBCSP) in 2006. To date, more than 300 endoscopists have now been accredited in England. The initial pass rate for Bowel Cancer Screening Accreditation (BCSA) is now 74%, rising to 87% following a second attempt. However, some candidates choose not to resit the accreditation test.

The mentoring of aspirant screening endoscopists, and ongoing support for practicing screening endoscopists within the programme (including management of underperforming screening endoscopists) are all dealt with in this document, as the support needs of these groups are broadly similar. The provision of continuous support through the mentorship scheme is a cornerstone of this document.

Within the NHSBCSP in England there have been occasional reports of screening endoscopists with complication rates that are higher than expected. Regional QARC teams have investigated the circumstances of these cases and have, where appropriate, recommended further training, and in some cases reaccreditation. These actions have been reactive, however, as there have been no clearly defined criteria for the supplementary training and reaccreditation of individuals who do not meet agreed QA standards.

While this is an uncommon problem and each case is different, the bowel cancer screening community feel that a well-defined, open, and fair process should be applied to all individuals who find themselves in this situation. This would ensure clarity and provide guidance for the handling of these sensitive cases in a professional, transparent, and equitable manner. It would also improve the structures for the support and supplementary training of screening endoscopists at all stages of the accreditation process, which is particularly necessary as individuals volunteer themselves to take part in this high-profile, closely monitored area of clinical practice.

This document offers guidance for best practice in cases where screening endoscopists need further support, and is not intended to be prescriptive. Since each case is unique, it is not possible to provide detailed guidance covering every scenario; instead a set of

generic principles and basic lines of responsibility are identified. Most cases will be dealt with locally within the programme, with input from the QARC team within PHE.

1.2 Stakeholders

The following groups have had input into this document:

- The JAG/NHSBCSP Accreditation Panel
- The NHSBCSP Endoscopy QA Group
- The Joint Advisory Group for Gastrointestinal Endoscopy (JAG)
- NHSBCSP screening endoscopists

1.3 Development of the accreditation process

Initial drafts of this document have been presented in a variety of meetings and forums and reviewed by many of the stakeholders above during a consultation period in 2010-2012.

As a result of this and other work, the accreditation process has been further developed. The introduction of Direct Observation of Polypectomy Skills (DOPyS) into the NHSBCSP was agreed in 2012. However, plans to require screening endoscopists to submit video cases of polypectomy have been reviewed and will **not** form part of the accreditation process. Video DOPyS may be required where further training is needed or where a review of polypectomy practice is required.

The development of a mentorship programme for aspirant and new screening endoscopists has been in place since mid-2012.

1.4 Context of the BCSA process

The strengths of the BCSA process are:

- It is fully established (it was set up in 2006)
- All bowel cancer screening endoscopists in England have been through the process
- It is well respected and internationally recognised
- The Direct Observation of Procedural Skills (DOPS) process has been prospectively validated
- There is an established training process for BCSA accreditors
- Feedback is supplied to BCSA accreditors on their Hawk/Dove index
- BCSA QA has been implemented, including
 - Feedback from candidates and accreditors
 - External QA shadow of all BCSA centres
- There are very few complaints/appeals about the BCSA QA process

The weaknesses of the BCSA process are:

- The lack of a firmly established structured training process for candidates before BCSA
- The fact that polypectomy has not been a mandatory or usual component of the BCSA process, despite being the cause of more significant complications
- Poorly-defined support mechanisms for candidates who do not pass the BCSA process
- A lack of guidance for screening endoscopists who do not meet minimum QA standards
- A lack of guidance on reaccreditation training and assessment processes

The current situation offers the opportunity to:

- Implement polypectomy as a mandatory part of the BCSA and reaccreditation process and to evaluate the impact of this prospectively
- Produce high quality training opportunities in polypectomy
- Develop a robust system for the prompt identification of screening endoscopists who are underperforming
- Develop a professional and supportive process for underperforming screening endoscopists
- Improve acceptance of the BCSA and reaccreditation process
- Extend the QA process to non-screening endoscopy in all modalities, thus raising endoscopy standards in England

The threats inherent in the current situation are:

- Loss of acceptance of the BCSA process
- Reduction in BCSA applications (leading to a decline in the number of screening endoscopists)
- Damage to the reputation of both the NHSBCSP in England and JAG if changes are poorly implemented

1.5 Aims of this document

The main aims of this document are:

- To set out a framework for supporting potential and new screening endoscopists via a mentoring programme for those working within the NHSBCSP (including bowel scope screening)
- To set out a framework for supporting screening endoscopists who do not meet the required QA standards

2. Mentoring programme for screening endoscopists

2.1 Definition of mentoring

A mentor can be defined as ‘a trusted counsellor or guide’. Mentoring is a well-established concept in healthcare and many other professions.

Mentoring can be:

- A formal process, in which a named person is formally allocated as a mentor with a specific remit to meet and counsel the mentee. The fact of the meeting is recorded, but the content is not always captured. This process can be helpful, but the imposition of a mentor can be resented, with the result that the process is wasteful of time and resources and ultimately ineffective
- An informal process, which forms an intrinsic part of effective and professional team working, in which the mentor is selected by the professional him/herself. Informal mentoring may involve
 - role modelling (copying the behaviour of an esteemed, usually senior colleague)
 - unstructured opportunistic discussions with peers and colleagues within a wide professional network, often facilitated by meetings (local/national). These discussions may be specifically sought out by the screening endoscopist him/herself
 - More formal structured discussions with peers or colleagues at regular scheduled audit meetings, adverse events meetings, appraisals and job plan discussions

2.2 Mentoring and endoscopists

To date, with limited exceptions, there has been no formal mentoring system for trained screening endoscopists in the UK. Almost all screening endoscopists engage in informal mentoring by interacting with their peers and colleagues at many different levels. They have many positive motivating reasons to do this, including self-assessment, the desire to be part of a team, and the wish to develop new skills. Screening endoscopists working in larger units with more colleagues have greater opportunities to take advantage of informal mentoring.

2.3 Mentoring and the screening endoscopist in difficulty

Many screening endoscopists in difficulty can be helped if positive action to address specific problems is undertaken. Often mentoring can be a useful and intrinsic part of this remedial process.

A screening endoscopist in difficulty will often be feeling threatened, vulnerable, unhappy, and aware of their own shortcomings, necessitating support from a mentor who is:

- Known to the screening endoscopist and liked by him or her – ideally a role model
- Chosen by the individual screening endoscopist in difficulty
- Geographically close
- A fellow professional with specialist knowledge and ideally some mentoring experience
- Able to devote time to this task
- Not part of the formal management structure of the screening endoscopist's directorate
- Able to access required facilities for remediation
- An acceptable choice to the management of the unit

In many cases, the availability of this type of support for a screening endoscopist in difficulty will obviate the need for formal management involvement and lead to a satisfactory outcome without the involvement of Human Resources (HR) colleagues.

The use of mentoring in this way is to be encouraged as it encompasses all the key principles of support and remediation for screening endoscopists in difficulty, whilst causing the least disruption to the service and the least cost to the organisation.

Any case where an individual is in difficulty should be overseen by the local screening centre director (unless the problem lies with that individual).

2.4 Mentoring responsibilities in the NHSBCSP

The mentor should:

- Be a screening endoscopist themselves and be recommended by their screening centre director
- Have received training in BCSP mentorship
- Be agreeable to the mentee (hence a choice of mentors should ideally be available)
- Be 'appointed' when an endoscopist expresses an interest in being a bowel cancer screening endoscopist
- Support the potential screening endoscopist through the pre-accreditation process
- Scope with the screening endoscopist before the accreditation (ideally to observe and be observed)

- Attend to support at least two screening colonoscopy lists following accreditation as a screening colonoscopist and observe polypectomy skills
- Support potential screening endoscopists in case of an inability to obtain accreditation at any stage
- Support new screening endoscopists as they become accustomed to their new screening role, as required
- Help facilitate training/professional development
- Support the screening endoscopist in difficulty (in case of complications, or poor KPIs)

It is important that the mentor does **not**

- Hold a position in which he or she is expected to assess the mentee.

Accreditation process for Screening Colonoscopists

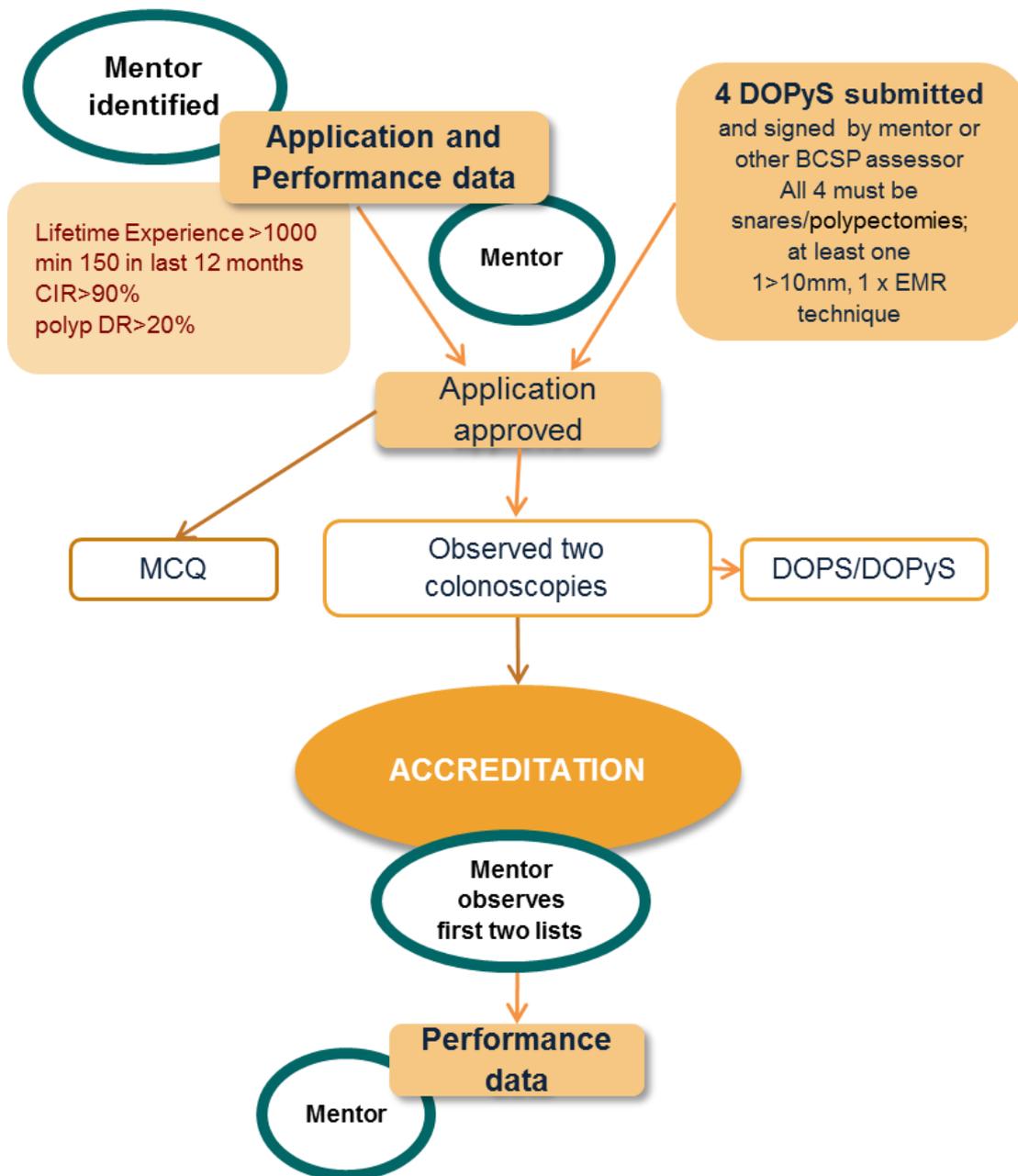


Figure 1a The mentorship of screening colonoscopists within the BCSA process

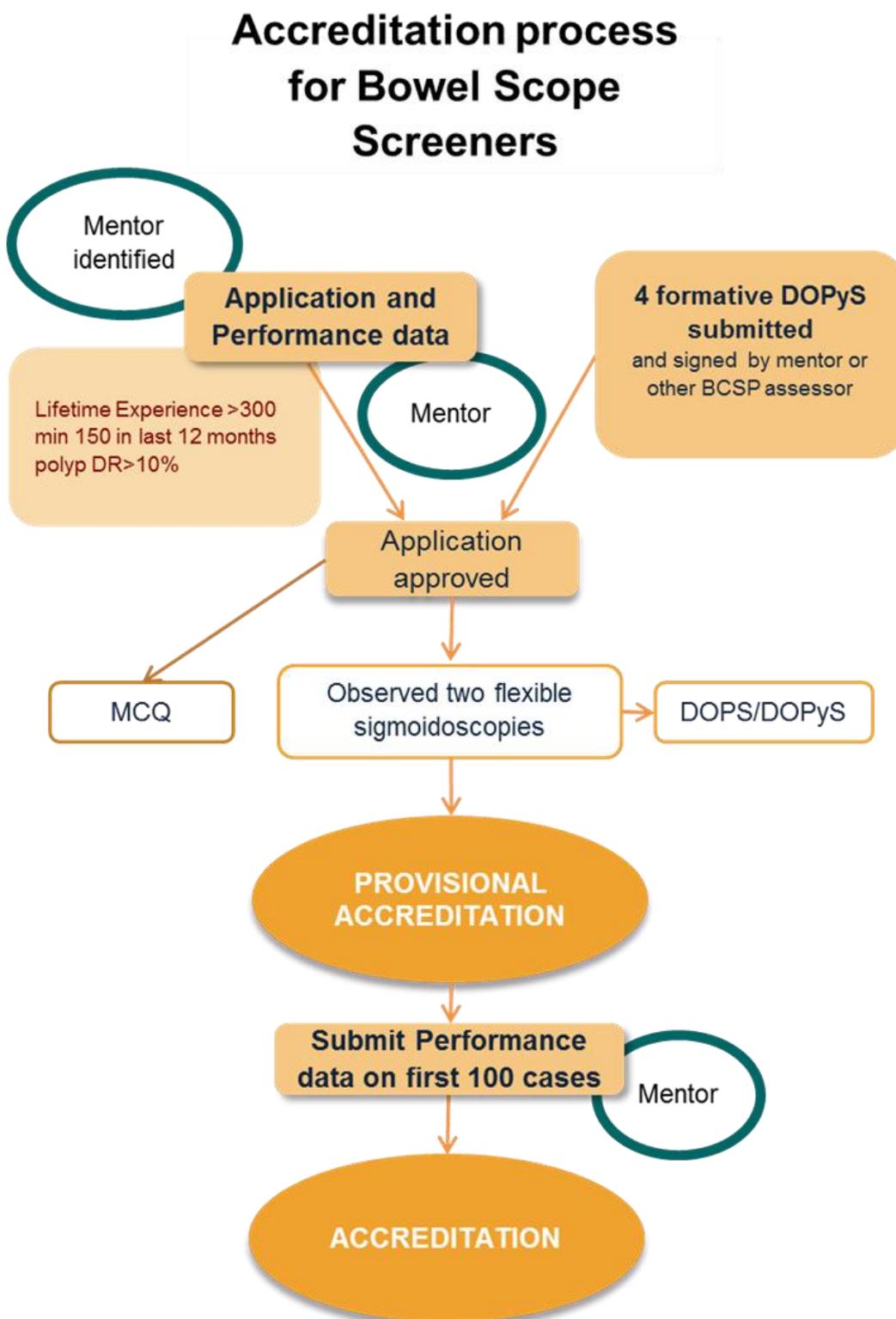


Figure 1b The mentorship of Bowel scope screeners within the BCSA process

3. Principles to be adopted with an endoscopist in difficulty

3.1 Definition of a screening endoscopist in difficulty

The definition of a 'screening endoscopist in difficulty' is an individual whose practice in endoscopy falls below current accepted standards of competence, exposing patients to an increased risk of harm. Alternatively, a screening endoscopist in difficulty may be technically competent but may display behaviours that compromise the integrity of the endoscopy team and the efficiency of the service.

There have always been problems with screening endoscopists in difficulty, but to date there has been no national guidance (other than generic HR guidance) on how to address or deal with these problems.

The NHSBCSP closely monitors the performance of screening endoscopists and therefore will readily identify those who do not meet the QA standards

It should not be assumed that any problems identified are entirely due to the individual alone, and wider issues such as the endoscopy team and environment should be considered in all cases.

3.2 Range of problems encountered

Some screening endoscopists in difficulty are experiencing deficiencies in competence. Lack of competence may be due to:

- Insufficient knowledge or skills when performing endoscopy
- Attitudes and behaviours that are harmful. Endoscopic Non-Technical Skills, or ENTS, are an intrinsic part of a screening endoscopist's competence and are as important as his or her knowledge and skills
- Issues relating to the way in which the screening endoscopist works within his or her team

Many screening endoscopists in difficulty have problems to a greater or lesser extent in all three of the above areas.

3.3 Principles to be adopted with a screening endoscopist in difficulty

The following principles should be adopted when dealing with a screening endoscopist in difficulty:

- Patient safety is the paramount consideration at all times
- Individual endoscopic styles may differ and competence should be judged taking this into account
- A low key approach should be adopted in the first instance, as some screening endoscopists have problems that are easily remediated with minimal intervention
- The approach, where possible, should be supportive
- Wherever possible, resolution of the problem should be local and issues should not be escalated to regional or national level unless this is unavoidable or mandatory (for example, when notification to the national office is mandated in NHSBCSP guidance)
- The resolution of any problems identified should be individually tailored to the screening endoscopist concerned
- The suspension of the screening endoscopist from practice should be used only as a last resort unless there are serious evidence-based concerns for patient safety
- It must be accepted from the outset that there are cost implications to addressing the problems of a screening endoscopist in difficulty, and that these can be considerable. However, these must be viewed in the light of the potentially greater costs of not addressing the problem

Clear, thorough, and timely documentation of all stages of the remediation process should be kept by the local screening centre director. If a case is escalated for external review by a screening centre director to a QARC team, a preliminary report with appropriate documentary evidence, and a summary of actions taken to date, should be provided. This may include:

- The NHSBCSP procedure log and KPIs
- The reason for referral
- Any local/regional/previous reassessment information
- Documentation related to process leading up to external review

3.4 Discovering problems with screening endoscopist performance

The problems of a screening endoscopist in difficulty may come to light in several ways:

- Via self-reporting by the screening endoscopist him/herself
- Via the observations of others
 - By reference to outcome measures, for example locally/nationally filed data such as KPIs
 - By a peer group, for example, direct colleagues
 - By co-workers, for example endoscopy assistants
 - By patients, either directly or through patient complaints

3.5 Triggers/thresholds for intervention

The following triggers should initiate further investigation:

- Self-reported problems: these must be taken seriously
- Concerns raised by colleagues: these may be raised by endoscopy nursing staff, endoscopy colleagues, or by patients. They may concern specific problems with the skills, knowledge, or behaviour of a screening endoscopist

These concerns may be raised:

- via the BCSA QA process
- via multi-source feedback (although this is slow, non-specific, and of uncertain validity)
- via the department manager or line manager (likely to be the lead endoscopist)
- anonymously through the Trust's 'whistle-blower' policy
- via a perceived excess number of complications
- via a perceived excess number of complications in the data (for example, a number of near-misses)
- via KPI data, where suboptimal data is noticed locally (for example, by lead consultants and others at routine audits) or regionally (for example via the QARC) or nationally

If the practice of the lead endoscopist him/herself is the cause for concern, there may be a delay in the formal recognition of this. Any concerns about a senior colleague must be raised with that individual's clinical manager, who may be a non-endoscopist. Concerns will usually need to be underpinned by an evidence base before allegations are made. KPI data may be a source of this information.

4. Solving problems

4.1 Problems of knowledge

These can be relatively easy to remedy. Remediation will generally consist of a combination of:

- Textbooks, e-learning, library resources
- Attending the lists of other screening endoscopists and discussing the findings from a selection of cases targeted at the knowledge gap
- Attending specific training courses/workshops targeted at the knowledge gap
- Assessment/proof of adequate resolution

4.2 Problems of skill

When problems concerning the lack of skills of a particular screening endoscopist come to the attention of the lead endoscopist/line manager, a stratified approach is indicated.

Only if there is a *significant* risk of patient harm should the screening endoscopist be suspended.

4.3 Informal approaches: coaching by colleagues

The screening endoscopist must either be given time to attend the lists of other colleagues, or other colleagues must attend the screening endoscopist's lists for hands on coaching/ training. In some cases, both approaches can be useful.

4.4 Formal approaches

4.4.1 Formal entry into a local retraining programme

This should be a jointly-agreed programme with designated outcomes or goals. It should only be used where there is minimal risk of patient harm. The programme should normally include no more than 2 or 3 learning outcomes (e.g. learning torque steering or patient re-positioning). This approach may need to be underpinned by a formal assessment after retraining, e.g. the DOPS process.

4.4.2 Formal entry into a specific retraining programme tailored to the screening endoscopist's practice

This is necessary where the screening endoscopist's practice is judged to constitute a significant risk to patient safety if uncorrected. It requires the screening endoscopist to have

sufficient insight into his/her practice to agree to the process. (Development of this insight might be assisted if the alternative to participation is suspension from endoscopic practice).

This type of retraining should be locally arranged where possible. It could comprise:

- The involvement of an external, recognised trainer/facilitator, necessitating cross-unit visits
- Attendance at a national training course, either as a delegate, observer, or even as faculty. However, used alone, this will rarely suffice. Normally such attendance needs to be built into a wider remedial programme

After formal retraining, there will usually be a need for an assessment, for example a DOPS process with specific standards. This may have to be a summative process if significant concerns were raised previously and patient safety is involved.

If at any stage the perceived lack of skills results in suspension from endoscopic practice because of concerns about patient safety, then any return to practice must be preceded by a DOPS process. Formal sign-off is necessary before the individual is reinstated.

4.5 Changing attitudes, behaviours, judgement

This is the most difficult of the three domains to tackle. The problems encountered range from the fairly mild to the extremely serious. A bespoke approach is required here, depending on the exact problem encountered.

A validated ENTS assessment may help to identify behaviours that need to be addressed and can facilitate formative feedback to the screening endoscopist.

Types of problems likely to be encountered include:

- Poor personal organisation e.g. persistent lateness for lists, inadequate notice of list cancellation, or unexplained failure to attend. All of these cause severe disruption to the service
- The inability to work effectively within a team, for example failing to fill in reports, sign books or prescriptions, or obtain histology sign-off
- Verbal abuse of colleagues and patients
- Inappropriate behaviour towards staff and patients
- Substance abuse

4.5.1 Informal discussions

The first approach to problems should be a discussion with a trusted senior colleague (for example a mentor or lead endoscopist) with an agreed outcome. This may or may not lead to a sustained change in behaviour. If not, a more formal approach is required.

4.5.2 Formal approaches

More formal approaches include advising the screening endoscopist to attend appropriate training. An ENTS training course for the NHSBCSP is currently under development.

HR may need to be involved, which usually requires a formal investigation by a senior colleague to establish the facts. In such cases, the medical director will be fully and formally involved. A full range of outcomes is possible, up to and including suspension and dismissal.

4.6 Cases where there are combined concerns

Each element of the concern (for example, problems with knowledge, skills, or attitudes) must be followed up with a specific plan for resolution.

Experience has shown that NHSBCSP endoscopists who experience problems with their practice are usually isolated from their local endoscopy unit's support mechanisms. This is due to the deliberate separation of the NHSBCSP from the general endoscopy service and the direct central reporting of KPIs. The mentor's role will therefore be crucial to supporting the screening endoscopist through this process.

5. Resolving difficult issues

5.1 Exercise of personal judgement

The following areas require fine judgement by peers and managers. It is not possible to provide definitive guidelines that can cover every case.

5.1.1 Thresholds of concern

It is important to be certain that the screening endoscopist's practice is actually substandard and not just a different or unusual style of practice from others.

5.1.2 Suspension

Full suspension from endoscopic practice should be avoided wherever possible because:

- It is a serious measure
- It has consequences for all concerned in the entire organisation and not just the individual
- It has implications for other areas of the screening endoscopist's practice
- It should be used sparingly and as a last resort (though it may sometimes be unavoidable)

Where there is serious concern about an aspect of a screening endoscopist's practice, the option of partial suspension has far fewer consequences. Partial suspension involves a screening endoscopist being prevented from performing particular, specific endoscopic techniques. Its advantages are:

- The screening endoscopist can withdraw from certain procedures following a supportive discussion. This removes the matter from the realm of 'suspension' with all its disciplinary overtones, but does not make withdrawal from certain areas of practice any less mandatory
- The suspension may be temporary or permanent
- The measure can be reversed following retraining and (in some cases) reassessment, for example a DOPS
- Withdrawal can be selective, thus ensuring that the screening endoscopist is only removed from performing NHSBCSP lists

5.1.3 Locating the problem

It is sometimes difficult to decide whether poor endoscopic outcomes are the result of a substandard screening endoscopist, a substandard endoscopic team, or a poor endoscopic service more generally.

An endoscopic service may be poor because it is inadequately equipped for the service required or because it is poorly managed. There are multiple possible causes in both cases.

Clear evidence of a screening endoscopist's underperformance, independent of service, centre, and team problems, must be obtained before blaming the individual screening endoscopist. This may require onsite observation of the screening endoscopist working within their team.

5.1.4 Developing insight

Problems of competence can be resolved more easily and satisfactorily when insight is present on the part of the screening endoscopist in difficulty. Insight arises from reflective practice, which comes more easily to some individuals than others. Capacity for insight is down to personality and is not something that can be easily 'learned' but mentors may be able help individuals to develop this faculty. The presence of insight is shown when the screening endoscopist either self-reports concerns or problems with their practice, or voluntarily registers for a relevant course.

Frequently, screening endoscopists who lack insight may have problems in other areas of their professional practice, which may be best addressed by seeking support from other senior colleagues outside of the endoscopy service.

5.2 The Rapid Diagnostic Framework

A framework for establishing whether an observed behaviour needs to be addressed can help determine whether there is a training need or whether the problem lies elsewhere, for example with health, personality, or organisational issues. The Rapid Diagnostic Framework is one such tool (Figure 2).

Figure 3 expands on the Rapid Diagnostic Framework, applying its process to underperformance in the BCSP. It outlines the process for dealing with a screening endoscopist in difficulty. A key aspect of any investigation of this type is to ensure that a record of all informal and formal discussions is kept in the interests of the screening endoscopist, the endoscopy team, and patients.

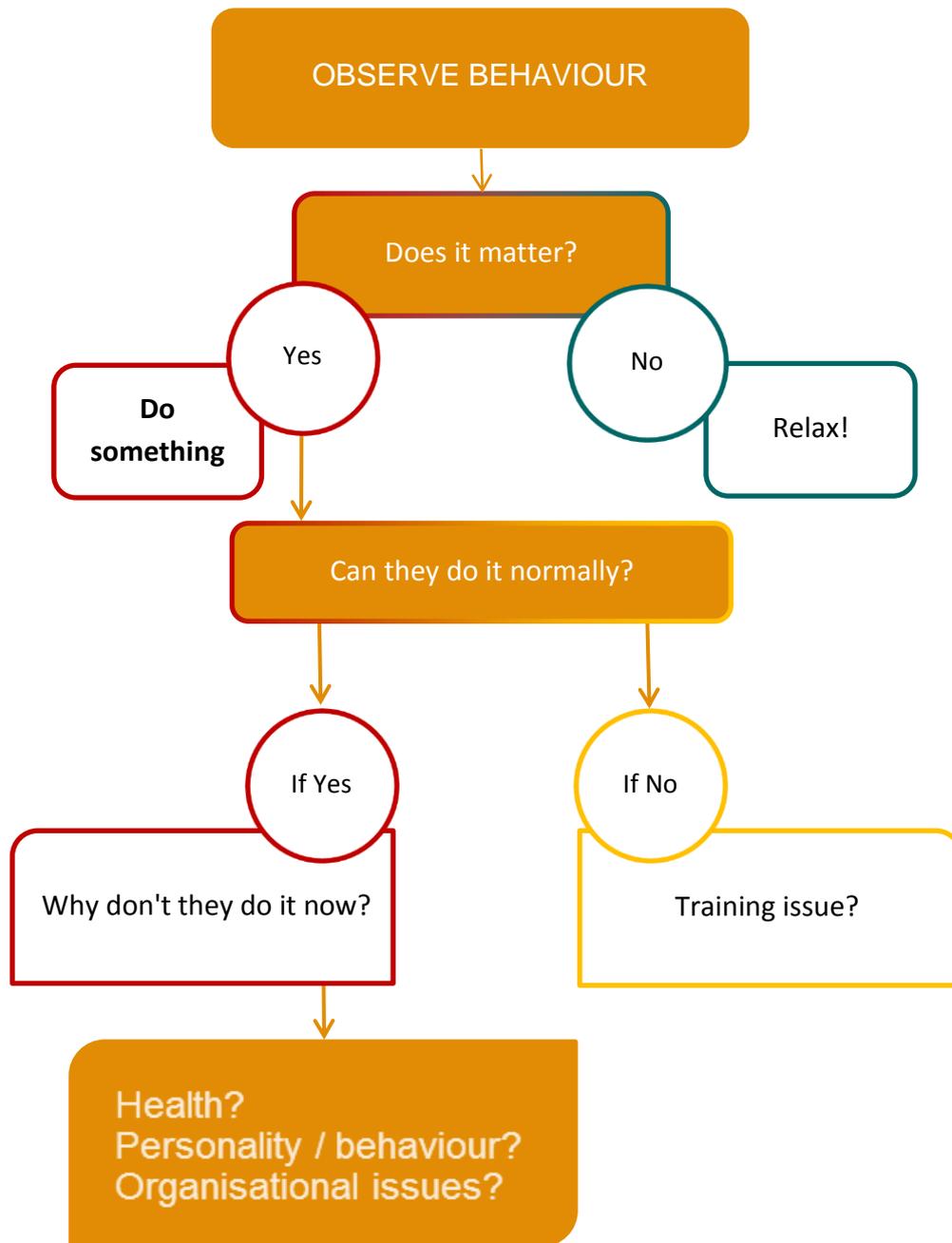


Figure 2 The Rapid Diagnostic Framework

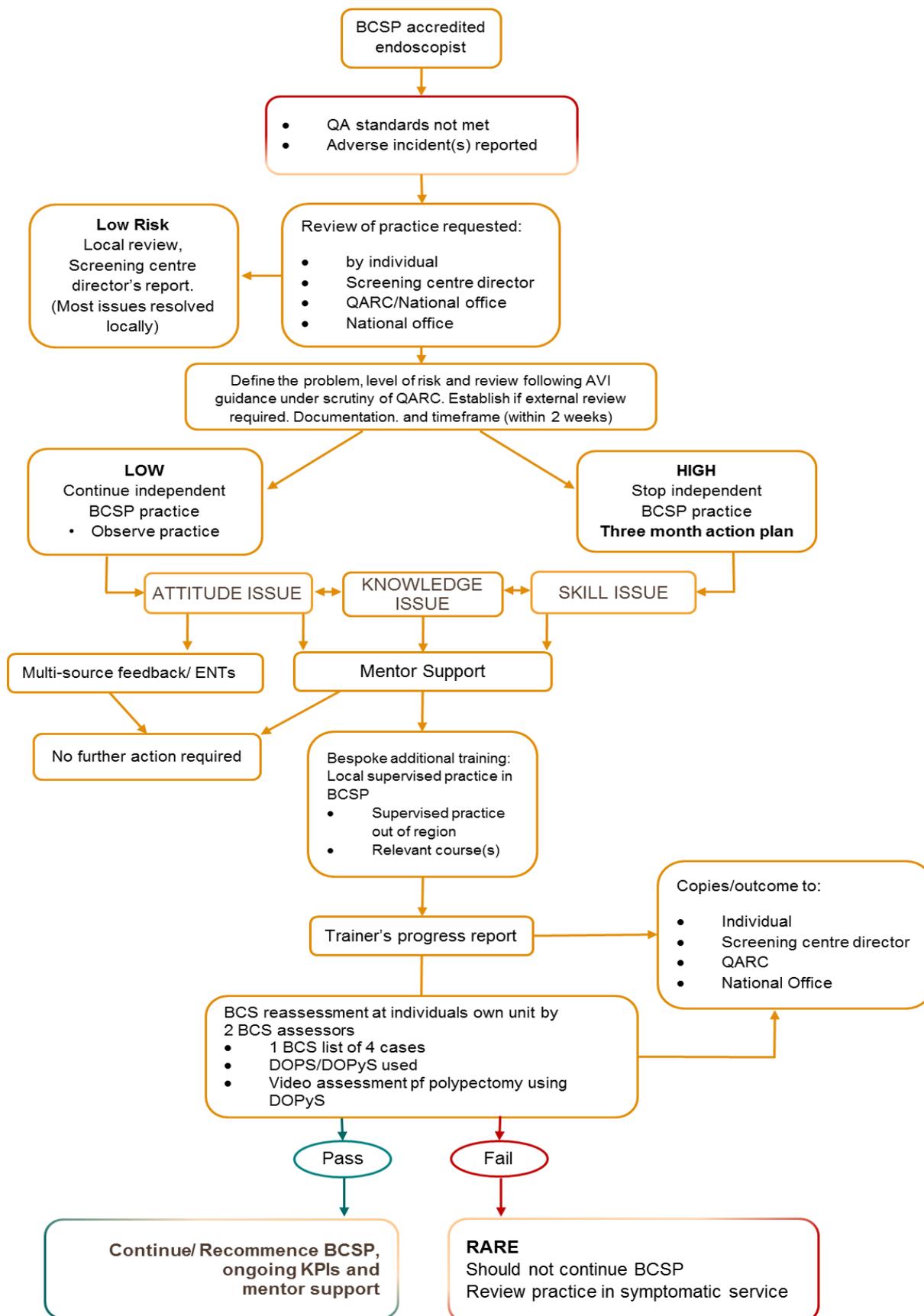


Figure 3 Flowchart showing the process for dealing with a screening endoscopist in difficulty

6. Reassessment

Supervised practice, retraining, and reassessment may be performed on screening patients under the supervision of a bowel cancer screening mentor/assessor. The use of video to reassess screening endoscopists in difficulty should be reserved for cases of clear underperformance.

Any formal reassessment of skills in bowel cancer screening should be performed by individuals who have been approved by the screening centre director and the regional QARC lead. Ordinarily, the assessors should come from different screening centres. Both must be experienced screening assessors.

The Quality Assurance director at the regional Quality Assurance Reference Centre (QARC) will be required to liaise with all stakeholders: the screening endoscopist, assessors, screening centre director, trainers, and staff at the screening centre hosting the reassessment. The liaison process should be determined at the time of referral. Consideration should be given to the issue of whether honorary contracts for external trainers or assessors are needed. The QA director must keep the screening endoscopist informed of the process at every stage.

The Chair of the Accreditation Panel will deal with appeals/complaints about the reaccreditation process, and will develop an appeal and complaints process including a timeframe for response.

A standard report should be developed to cover the whole reassessment of skills process (including DOPS and DOPyS where necessary). Additionally, further guidance covering the reassessment process will be developed in future. This should cover:

- Confidentiality
- Contents of the initial plan of action from the QARC, to be sent within 2 weeks
- The timeframe for agreeing reassessment dates
- Report writing timescales need to be set
- Reimbursement to the screening centre for the assessor's time in undertaking reassessment

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