


**OMED COLORECTAL CANCER SCREENING COMMITTEE MEETING**  
**Saturday, May 1, DDW New Orleans, 2010**  
**Presenter: Roland Valori**




**World Organisation of Digestive Endoscopy**

**Colorectal Screening Committee**

**Roland Valori**

Quality measures and their validation




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**Polypectomy quality measures**

- Competency and performance
- Competency framework
- Performance measures
- Monitoring performance

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**Colonoscopy: quality and safety**

	Expert	Inexpert
Completion	>95%	<90%
Perforation rate	<1:5000	>1:1000
Cancer 'miss' rate	1%	10%
Completeness of polyp excision	complete	often incomplete
Serious polypectomy complications	<1:200	>1:100
Patient experience	usually good	often bad
Appropriateness of repeats	yes	often no

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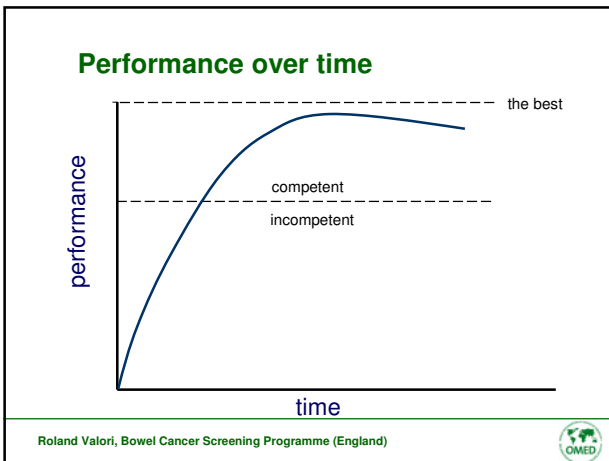
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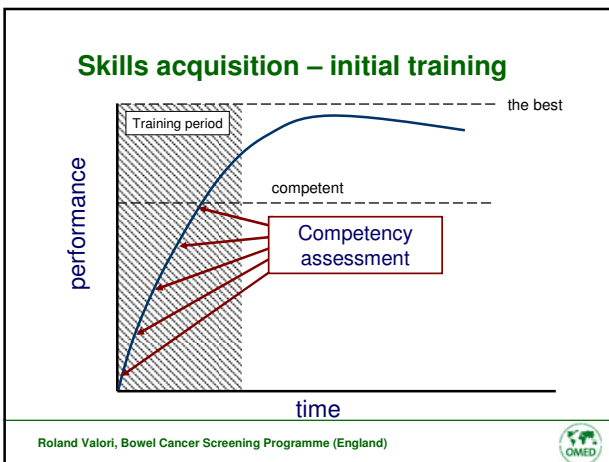
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### Formative Colonoscopy & FS DOFS Assessment Form - JAG approved

Colonoscopist: \_\_\_\_\_ Date: \_\_\_\_\_ Trainer/Peer: \_\_\_\_\_

Major criteria       Minor criteria

Criteria	Score	Comments
<b>Assessment, Consent, Communication</b> <ul style="list-style-type: none"> <li>Obtain informed consent using a structured approach</li> <li>Deliver procedural information</li> <li>Dis &amp; complications explained</li> <li>Consentably</li> <li>Selection</li> <li>Opportunity for questions</li> <li>Demonstrate respect for patient's views and mobility during the procedure</li> <li>Communicate clearly with patient throughout, including the results of the procedure with appropriate handover and follow up.</li> </ul>		
<b>Safety &amp; Sedation</b> <ul style="list-style-type: none"> <li>Safe and secure fit device</li> <li>Give appropriate dose of analgesic and sedation and ensure adequate oxygenation and monitoring of patient</li> <li>Demonstrate good communication with the nursing staff, including through a full handover</li> </ul>		
<b>Endoscopic Skills during insertion &amp; withdrawal</b> <ul style="list-style-type: none"> <li>Checks endoscope function before insertion</li> <li>Perform FIT</li> <li>Maintain luminal view / inserts in luminal direction</li> <li>Demonstrate awareness of patient's consciousness and pain during the procedure and take appropriate action</li> <li>Use torque steering</li> <li>Use dilation, suction &amp; lens washing appropriately</li> <li>Recognise &amp; logically resolve loop formation</li> <li>Use position change and abdominal pressure to aid luminal views</li> <li>Complete procedure to mucosal line</li> </ul>		
<b>Diagnostic &amp; Therapeutic Ability</b> <ul style="list-style-type: none"> <li>Adequate mucosal visualisation</li> <li>Recognise capabilities, order techniques or incomplete examination</li> <li>Accurate identification &amp; management of pathology</li> <li>Use diagnostic and therapeutic techniques appropriately and safely</li> <li>Recognise &amp; manage complications appropriately</li> </ul>		

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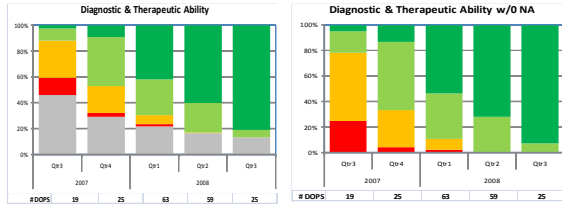
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**DOPS progression outputs**

Data for one domain, with and without 'Not Assessed' (grey)



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**Mandatory competence test for colonoscopists in the English FOBT screening programme**

- Review of performance indicators
- Knowledge test: MCQ
- Competency test: DOPS
  - 2 routine surveillance colonoscopies
  - 2 examiners at examination centre
  - Structured framework of competencies
  - Examiners intervene in difficult cases
  - Time limited

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**Accreditation test results - July 2009**

- 162 candidates assessed
- 193 assessments
  - 126/162 (78%) candidates met the criteria first time
  - 31 repeat assessments (4 for breach of protocol)
    - 27 had one further assessment
    - 2 had two further assessments
- In total, 146 of 162 have now met the criteria (90%)

Currently >275 colonoscopists have been through the process

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**Predicted reliability of DOPS assessment**

Assessors	Cases				
	1	2	3	4	5
1	0.65	0.71	0.73	0.74	0.75
2	0.76	0.81	0.83	0.84	0.85
3	0.80	0.86	0.87	0.88	0.89
4	0.83	0.88	0.90	0.90	0.91
5	0.84	0.89	0.91	0.92	0.92

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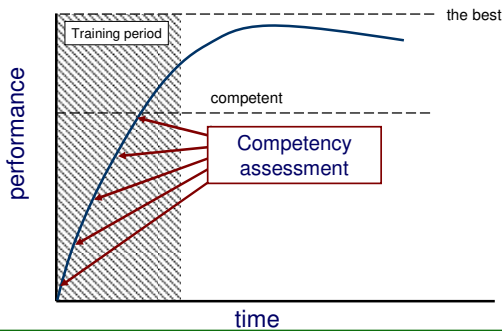
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**Polypectomy training**



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**Removing high risk colonic lesions**

Get to, and identify a lesion

Recognise what it is

Make a decision about what to do

Remove the lesion safely and completely, and retrieve it

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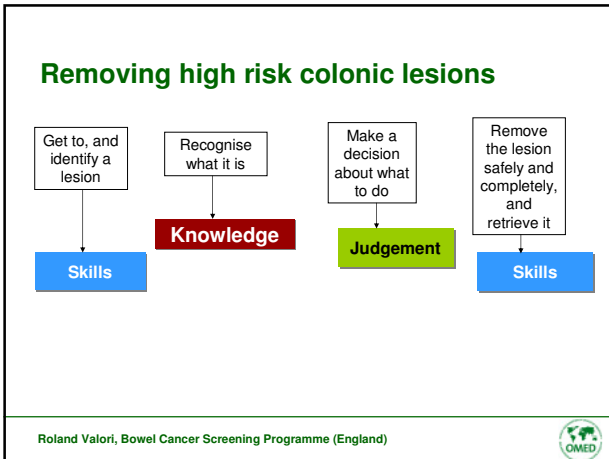
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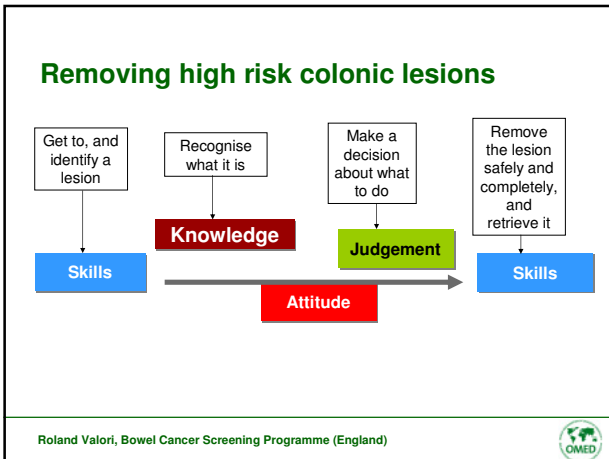
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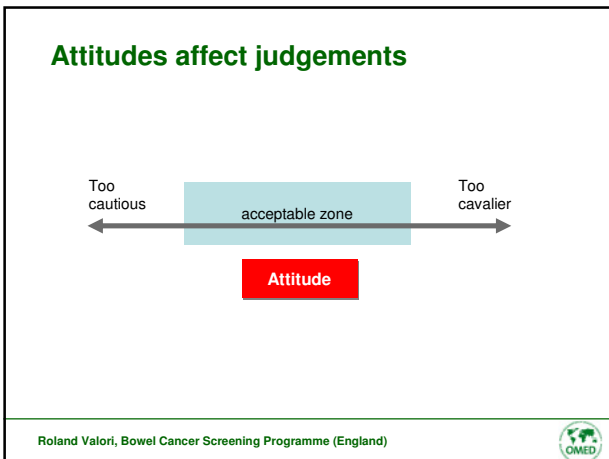
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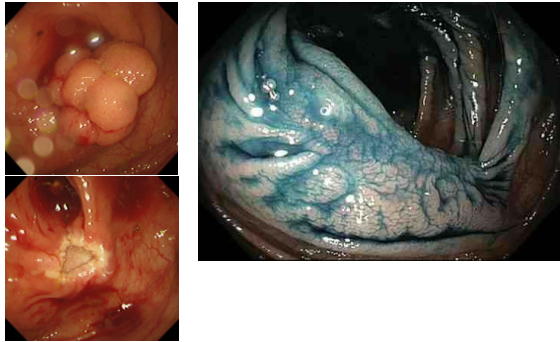
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**Not all polyps are equal**



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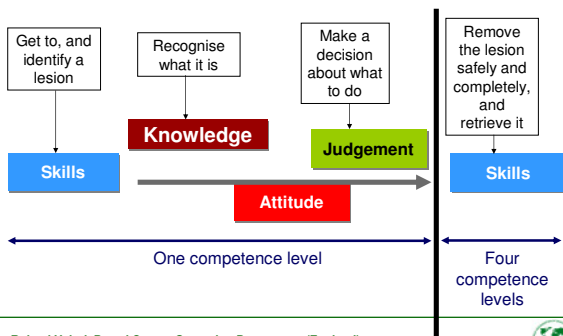
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**Removing high risk colonic lesions**



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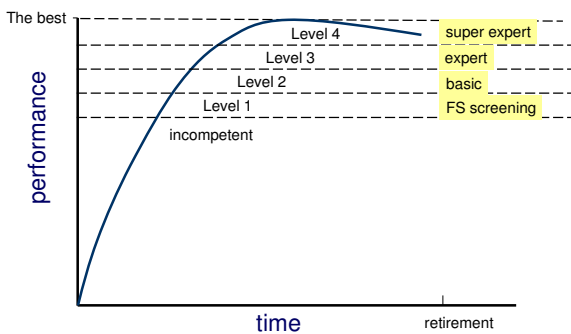
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**Performance levels for polypectomy**



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**DOPyS domains**

- Generic skills**
- Stalked polyps**
- Sessile polyps/EMR**
- Post-polypectomy**

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**Video DOPyS Project: Validation**

- All BCS England endoscopists invited to take part
- 30 randomised to provide videos
- Collection of 60 BCS polypectomy videos
- Scored by 7 experienced endoscopists:
  - Gastroenterologists, Surgeon, Nurse
- 11760 pieces data

Project lead by Dr Siwan Thomas-Gibson,  
St Mark's Hospital

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**Assessor variation of DOPyS assessment**

- Lack of agreement of
  - optimal technique
  - where to set the bar on the pass/fail divide
- Assessing videos is suboptimal
- Majority of polyps were level1 and 2

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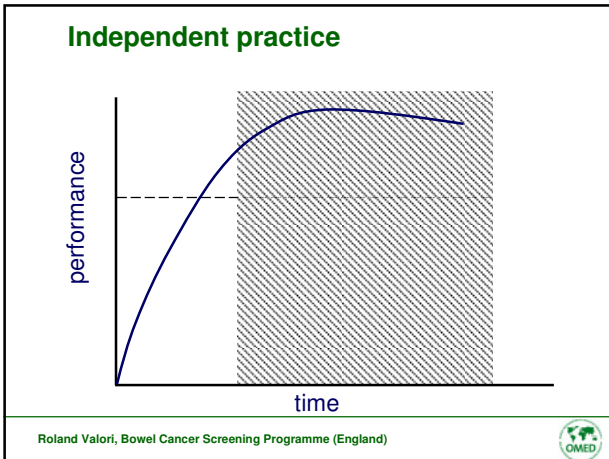
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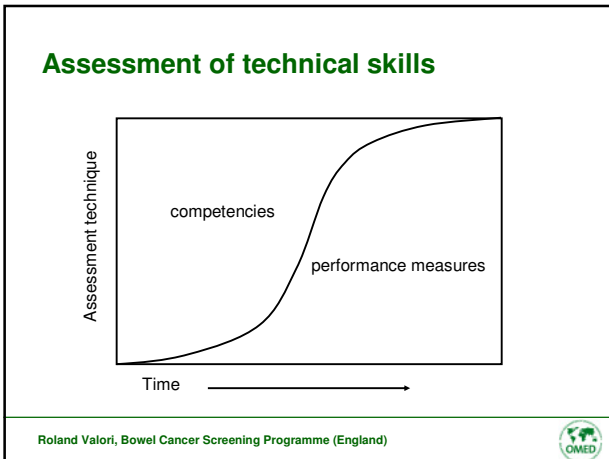
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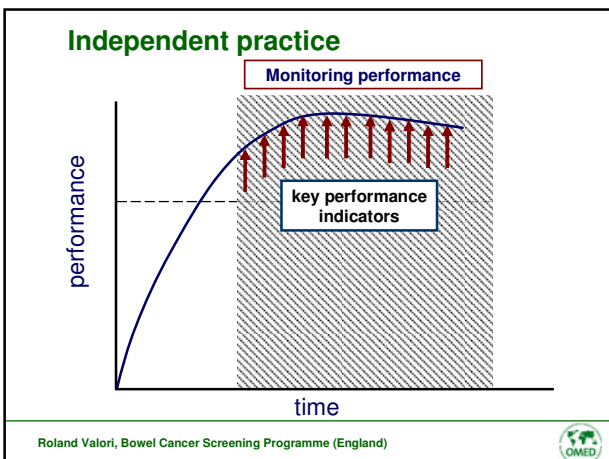
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**What outcomes matter to the patient?**

	<b>Hypertension</b>		
	Monitoring BP		
	Control of BP		
	Stroke and death		

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**What outcomes matter to the patient?**

	<b>Hypertension</b>	<b>Polypectomy</b>	
	Monitoring BP	Withdrawal times	
	Control of BP	Adenoma detection	
	Stroke and death	Cancer and death	

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**What outcomes matter to the patient?**

	<b>Hypertension</b>	<b>Polypectomy</b>	<b>Ease of measurement</b>
	Monitoring BP	Withdrawal times	Easy
	Control of BP	Adenoma detection	Moderate
	Stroke and death	Cancer and death	Hard

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**What outcomes matter to the patient?**

	Hypertension	Polypectomy	Ease of measurement
Surrogate of surrogate	Monitoring BP	Withdrawal times	Easy
Surrogate	Control of BP	Adenoma detection	Moderate
Direct	Stroke and death	Cancer and death	Hard

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**Hierarchy of outcome measures**

- Withdrawal time
  - Adenoma detection rates
  - 'High risk' adenoma detection rates
  - Incomplete excision rates
  - Complications
  - Cancer 'miss rates'
    - cancer rates in surveillance programmes
- Can we define target rates for these measures?

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**Auditable outcomes and performance indicators**

- **Auditable outcome** is something we believe should be measured but for which there is not a defined numerical standard
- **Performance indicator** is measure for which we have a defined acceptable standard

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**Validating performance measures**

Elevating 'auditable outcomes' to performance indicators

- Clearly defined measures
  - everyone is measuring the same thing
- Clearly defined samples
  - everyone uses the same denominator
- Accurate measurement
  - everyone assesses the numerator precisely

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**At what level should performance be monitored?**

			Individual	Service	Programme
Withdrawal time					
Adenoma detection					
Incomplete excision					
Complications					
Cancer					

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**At what level should performance be monitored?**

	Rate	Freq	Individual	Service	Programme
Withdrawal time	6+	Hi			
Adenoma detection	20%	Hi			
Incomplete excision	5%	Lo			
Complications	0.5%	Lo			
Cancer	1-5%	V. Lo			

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**At what level should performance be monitored?**

	Rate	Freq	Individual	Service	Programme
Withdrawal time	6+	Hi	++++	-	-
Adenoma detection	20%	Hi	+++	+	+
Incomplete excision	5%	Lo	+++	+	-
Complications	0.5%	Lo	+	+++	++
Cancer	1-5%	V. Lo	+/-	+++	++++

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**Polypectomy quality measures**

- Competency and performance
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- Performance measures
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