Setting up a National Quality Program

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Gloucestershire Hospitals, UK
Trend in adenoma detection rates in Scottish and English screening programmes

Adenoma Detection Rate

- Men: 37%
- Women: 49%

Graph showing the trend from 2007 to 2014 for both men and women.
What did we do differently in England?

• Quality assured before we started:
  – units
  – colonoscopists

• Measured and fed back performance data:
  – units
  – colonoscopists

• Acted on poor performance:
  – units
  – colonoscopists
National Clinical Director Endoscopy - 2003

- Appointed 2003 – with a budget!
Needed a measure of progress:

What would matter to you if you were having an endoscopy?

2004
Patient-centred standards
- endoscopy global rating scale (GRS)

Clinical quality
- appropriateness
- information/consent
- safety
- comfort
- quality
- timely results

Quality of patient experience
- equality
- timeliness
- choice
- privacy and dignity
- aftercare
- ability to provide feedback

www.grs.nhs.uk
# Four domains of the GRS

<table>
<thead>
<tr>
<th>1. Clinical quality</th>
<th>2. Quality of the patient experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information/consent</td>
<td>1. Equality of access</td>
</tr>
<tr>
<td>2. Safety</td>
<td>2. Timeliness</td>
</tr>
<tr>
<td>4. Quality</td>
<td>4. Privacy and dignity</td>
</tr>
<tr>
<td>5. Appropriateness</td>
<td>5. Aftercare</td>
</tr>
<tr>
<td>6. Results to referrer</td>
<td>6. Patient feedback</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Staff</th>
<th>4. Training endoscopists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Skill mix review and recruitment</td>
<td>1. Environment and opportunity</td>
</tr>
<tr>
<td>2. Orientation and training</td>
<td>2. Endoscopy trainers</td>
</tr>
<tr>
<td>3. Assessment and appraisal</td>
<td>3. Assessment and appraisal</td>
</tr>
<tr>
<td>4. Staff are cared for</td>
<td>4. Equipment and materials</td>
</tr>
<tr>
<td>5. Staff are listened to</td>
<td></td>
</tr>
</tbody>
</table>
## Quality of the Procedure

A key quality indicator refers to a measure with a predefined standard such as caecal intubation rate of >90%. An auditable outcome is a measure for which an audited standard is defined. Usually there will be an evidence base to support a standard for a quality indicator, but not for an auditable outcome. A unit may wish to attach a standard for one of its auditable outcomes, whereupon it would become a quality indicator.

<table>
<thead>
<tr>
<th>No</th>
<th>Measure</th>
<th>Level</th>
<th>Evidence</th>
<th>Hover</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Key quality indicators and auditable outcomes defined by the BSG for the procedures performed in the unit are available in the department in written and electronic form</td>
<td>Level D</td>
<td>Assessed on the day</td>
<td>None</td>
</tr>
<tr>
<td>4.2</td>
<td><strong>Systems are in place for monitoring level C BSG auditable outcomes and quality standards</strong></td>
<td>Level C</td>
<td>Evidence of rolling audit programme</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A rolling audit programme for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.  Number of procedures performed by each operator</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>2.  Success of intubation of OGD</td>
<td></td>
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<tr>
<td></td>
<td>3.  Completion of OGD</td>
<td></td>
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<tr>
<td></td>
<td>4.  Colonoscopy completion rate</td>
<td></td>
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<tr>
<td></td>
<td>5.  Adenoma detection rate</td>
<td></td>
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<tr>
<td></td>
<td>6.  Sedation and analgesia for colonoscopy</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>7.  Quality of bowel prep</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8.  Satisfactory placement of PEG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td>The outcomes and standards are reviewed on a regular basis (at least 2x/year)</td>
<td></td>
<td>Evidence of rolling audit programme with dates of completion</td>
<td>None</td>
</tr>
<tr>
<td>4.4</td>
<td>Individual endoscopists are given feedback on their immediate outcomes and standards at least 2x/year and audits of their late outcomes at least once/year</td>
<td></td>
<td>Evidence of feedback (letter, minutes, actions of Endoscopy Users Group for example)</td>
<td>None</td>
</tr>
<tr>
<td>4.5</td>
<td>Action is agreed with an individual if performance falls below acceptable levels</td>
<td>Level B</td>
<td>Evidence of communication with individuals e.g. letters</td>
<td>None</td>
</tr>
<tr>
<td>No</td>
<td>Measure</td>
<td>Level</td>
<td>Evidence</td>
<td>Hover</td>
</tr>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>4.6</td>
<td>Auditable goals and timescales for the above action are agreed and monitored</td>
<td></td>
<td>Evidence of feedback (letters, minutes, actions of Endoscopy Users Group for example)</td>
<td>None</td>
</tr>
<tr>
<td>4.7</td>
<td>There is an IT system in place to capture immediate auditable outcomes and quality standards</td>
<td></td>
<td>Unit visit assessment</td>
<td>None</td>
</tr>
<tr>
<td>4.8</td>
<td>Systems are in place for monitoring level ‘B’ BSG auditable outcomes and quality standards*</td>
<td></td>
<td>Schedule of rolling audit programme and level B audits</td>
<td>A rolling audit programme for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Level A</td>
<td>9. Repeat endoscopy for gastric ulcers within 12 weeks.</td>
<td>10. Colonic polyp recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>11. Completion of intended therapeutic ERCP</td>
<td>12. Decompression of obstructed ducts</td>
</tr>
<tr>
<td>4.9</td>
<td>Systems are in place for monitoring level ‘A’ BSG auditable outcomes and quality standards*</td>
<td></td>
<td>Schedule of rolling audit programme and level A audits</td>
<td>A rolling audit programme for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15. Satisfactory position of metallic stent for oesophageal obstruction</td>
<td>16. Diagnostic biopsies for diarrhoea</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17. All quality outcomes for EUS</td>
<td></td>
</tr>
<tr>
<td>4.10</td>
<td>Actions taken in response to poor performance are reviewed within agreed timescale</td>
<td></td>
<td>Evidence of feedback (letters, minutes, actions of Endoscopy Users Group for example)</td>
<td>None</td>
</tr>
<tr>
<td>4.11</td>
<td>Endoscopists that fail to achieve agreed standards, after an agreed implementation plan, have their practice reviewed by the Trust Clinical Governance/Risk committee (tick yes if agreed standards are acceptable for all endoscopists)</td>
<td></td>
<td>Evidence of minutes and actions</td>
<td>None</td>
</tr>
</tbody>
</table>
Each item has 4 levels

<table>
<thead>
<tr>
<th></th>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate</td>
<td>D</td>
<td>Minimal achievement</td>
</tr>
<tr>
<td>Basic</td>
<td>C</td>
<td>Reactive</td>
</tr>
<tr>
<td>Good</td>
<td>B</td>
<td>Proactive</td>
</tr>
<tr>
<td>Excellent</td>
<td>A</td>
<td>Outward looking</td>
</tr>
</tbody>
</table>

Level B was the initial standard
Doctor response to the GRS

“When I first saw the GRS I have to be honest and say that I printed it, read it, ripped it up and chucked it in the bin.

I had no intentions of ever doing anything with it. Slowly I saw what was going on around me and I had another look.

I now truly believe that its been the single most important thing that has helped us to improve our service. I feel somewhat embarrassed at my initial reaction.”

Endoscopy Unit Clinical Lead
The patient’s view of endoscopy 2001

- Chaotic
- Long waits
- Poor communication
- Poor environment
- Poor experience

Thanks to Dr Bill Goddard
Nottingham University Hospitals
250,000 waiting for an appointment in 2004

“Age? You mean now or when we first sat down?”
GRS Results: April 2005 – April 2012

Percentage scoring A or B

Completion rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Apr</th>
<th>Oct</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>85%</td>
<td>94%</td>
</tr>
<tr>
<td>2006</td>
<td>100%</td>
<td>97%</td>
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<tr>
<td>2007</td>
<td>97%</td>
<td>98%</td>
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<tr>
<td>2008</td>
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<td>2009</td>
<td>96%</td>
<td>97%</td>
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<tr>
<td>2010</td>
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<td>100%</td>
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<tr>
<td>2011</td>
<td>99%</td>
<td>98%</td>
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<tr>
<td>2012</td>
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<td>98%</td>
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</table>

Clinical quality

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<tbody>
<tr>
<td>Consent</td>
<td>85%</td>
<td>94%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
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<tr>
<td>Safety</td>
<td>85%</td>
<td>94%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
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<tr>
<td>Comfort</td>
<td>85%</td>
<td>94%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
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<tr>
<td>Quality</td>
<td>85%</td>
<td>94%</td>
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<tr>
<td>Appropriate</td>
<td>85%</td>
<td>94%</td>
<td>100%</td>
<td>97%</td>
<td>97%</td>
<td>99%</td>
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</tr>
<tr>
<td>Results</td>
<td>85%</td>
<td>94%</td>
<td>100%</td>
<td>97%</td>
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<td>98%</td>
</tr>
</tbody>
</table>
Closing the performance gap

- The GRS

self assess against the requirements

the standard

status quo

performance

time
10 National endoscopy training centres

28 Regional Clinical Leads

10 National endoscopy training centres

2005
Closing the performance gap

- self assess against the requirements
- peer review
- the standard
- accreditation
- status quo
### JAG Accreditation in April 2018

<table>
<thead>
<tr>
<th>Status</th>
<th>Acute Units</th>
<th>Community Units</th>
<th>Independent Units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed: Criteria met</td>
<td>121</td>
<td>20</td>
<td>49</td>
<td>190</td>
</tr>
<tr>
<td>Assessed: Improvements required</td>
<td>45</td>
<td>3</td>
<td>10</td>
<td>58</td>
</tr>
<tr>
<td>Assessed: Accreditation not awarded</td>
<td>28</td>
<td>1</td>
<td>0</td>
<td>29</td>
</tr>
<tr>
<td>Not assessed: Visit pending</td>
<td>7</td>
<td>0</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Not assessed</td>
<td>11</td>
<td>9</td>
<td>92</td>
<td>112</td>
</tr>
<tr>
<td>Total</td>
<td>212</td>
<td>33</td>
<td>154</td>
<td>399</td>
</tr>
</tbody>
</table>

**NB:** Acute sector (160 organisations) does 90% of the activity, all the complex work and most of the training.
JAG accreditation

• Improved important outcomes
• Reduced future costs
• Reduced risk
• Improved patient experience
• Empowered clinical leaders and their teams
• Completely changed the culture
• Required collaborative working nationally and locally
Accreditation - the endoscopy model

- **Self assess** against the requirements
- **Peer review**
- **Status quo**
- **Accreditation**
Competence, performance and expertise

the best

expert

competent

incompetent

performance

time

retirement
Mandatory competence test for colonoscopists in the screening program

- >300 have been through the process
  - performance data
  - knowledge test
  - observed doing two colonoscopies by two trained assessors
- 78% met the criteria the first time
- 90% eventually meet the criteria
Dealing with concerns about performance
BCS endoscopist
QA standards not met
serious adverse incident/s
review of practise requested: by self; screening director; regional QA lead; national office
KPIs, screening director's report
request external review
agree plan
appoint QA team to investigate
Problem assessed and plan made within 2/52 (All discussions, interventions documented)

Concern
attitude
knowledge
skill
ENTS/360°
mentor support
no further action

HIGH
stop independent BCSP practise 3/12 plan

LOW
Continue BCSP with observation

BLEND 360° feedback

bespoke additional training: Local supervised practice in BCSP
Out of region Courses

reassessment by DOPS/DOPyS knowledge test
BCS reassessment screener's own unit
2 BCS assessors
1 BCS list, 4 cases
DOPS / DOPyS used

continue/re-enter BCSP ongoing KPIs & mentor support

trainer's progress report
QA team review data & agree outcome

RARE
Should not continue BCSP
Report to: Screener Medical director National QA BCSP

(All discussions, interventions documented)
Acquiring colonoscopy and polypectomy skills

- expert
- competent

- intubation
- detection
- therapy

performance vs. time
Performance levels for polypectomy

The best performance

Level 4
Level 3
Level 2
Level 1
incompetent

FIT +ve colonoscopy
tertiary
basic colonoscopy
FS screening

Test of competencies to jump a level, or to determine whether someone should go down a level
Is your country adequately prepared for colorectal cancer screening?

What needs to be in place?
Leadership at national level

Surgeons, physicians, nurses and patients should work in partnership with national and regional healthcare ministries to develop a strategy for high quality and safe colonoscopy which must include:

- agreed standards for endoscopy
- processes for measuring and improving quality including a
- training programme to retrain poor performers
- a national KPI reporting system for quality (PCCRC) and harm
- a governance oversight group for endoscopy
Four guidelines or quality frameworks for endoscopy services identified

1. EU guideline: Quality Assurance of CRC Screening: Chapter 5, Endoscopy
2. Canadian Association of Gastroenterology consensus guideline on quality and safety indicators in endoscopy
3. ASGE: Quality Indicators for Gastrointestinal Endoscopy Units
4. UK Global Rating Scale
5. ESGE Endoscopy Services Measures
30 statements in nine domains

1. Leadership and Organisation (2)
2. Facilities and Equipment (4)
3. Quality (4)
4. Safety (5)
5. Appropriateness (1)
6. Information, Consent and Further Care (3)
7. Comfort, Privacy and Dignity (3)
8. Staffing (5)
9. Patient feedback (3)
Quality

3.1 We recommended endoscopy services to have systems in place for capturing and presenting key endoscopy performance indicators for all procedures undertaken in the service

• **Minimum standard**: a list of procedural indicators based on ESGE and/or national body guidelines. An endoscopy reporting system (ERS), or equivalent, to capture procedural indicators continuously.

• **Target standard**: a system for collating and presenting individual and summary performance data for all procedures performed in the service.
Leadership at regional level

• Develop local quality improvement networks to:
  – share best practice
  – create referral pathways for complex procedures
Leadership at local level

- Ensure systems are in place to monitor KPIs
- Ensure there are processes in place to feedback performance data
- Ensure there is a process for managing poor performance
- Support those in need of further training
- Ensure capacity is fully utilised
Leadership and organisation

1.1 We recommend endoscopy services have a competent leadership team with defined roles and responsibilities, including a description of accountability.

1.2 We recommend endoscopy services be organised to acquire the necessary resources to deliver the service and to maximise utilization of these resources while maintaining high patient satisfaction, quality and safety.
Individual endoscopists

- Make the assumption you can be better
- Measure and benchmark your performance
- Identify training needs and respond to them
- Stop doing endoscopy if minimum standards are not achieved with further training
Thank you