EGGNZ

The Endoscopy Guidance Group for New Zealand

Guidance for managing and supporting underperformance of endoscopists in New Zealand

Produced by:	The Endoscopy Guidance Group for New Zealand (EGGNZ).
Date:	April 2020
Status:	FINAL

Introduction

A basic tenet of a patient-centred endoscopy service is that all endoscopists practise at a high level. This implies a safe level of competence and skill demonstrated through accepted indicators of performance and clinical outcomes. Endoscopists who do not reach or maintain this level need to be identified and managed using a supportive framework embedded within the governance process of an endoscopy unit.

Much work has been undertaken in New Zealand in recent years to improve the quality of endoscopy. This has been achieved in a variety of ways by the introduction of a national quality improvement programme (NEQIP) and a service improvement tool, the New Zealand Global Rating Scale (NZGRS), setting individual standards (Endoscopy Guidance Group for New Zealand (EGGNZ), credentialing guidelines and the National Bowel Screening Programme (NBSP) – specific guidelines, along with attempts to improve training (Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy New Zealand (CCRTGENZ)) and assessment (Gastroenterology Society of Australia (GESA) Colonoscopy re-credentialing).

The NZGRS requires endoscopy units to monitor quality of both endoscopy and individual performance. Standards 4.2, 4.3 and 4.4 of the Quality Domain and 3.4 of the Comfort Domain in the NZGRS stipulate that key performance indicators (KPI's) will be monitored, reported to the Endoscopy User Group (EUG) and fed back to the endoscopists on a minimum 6 monthly basis.

Occasionally there will be instances where endoscopy performance falls below the minimum standards considered acceptable for patient care (i.e. underperformance). There is currently no established framework to support practitioners in difficulty. Struggling endoscopists may be technically competent, but have behaviours that compromise the efficient functioning and integrity of the endoscopy team and service. It should not be assumed that issues raised are entirely due to the individual alone and wider issues and team and environment should be considered in all cases.

This EGGNZ guidance provides service leads and endoscopists in New Zealand with a dedicated framework (Figure 1) for managing suspected underperformance, based on published expert opinion[1] and the British Joint Advisory Group on GI Endoscopy (JAGUK) recommendations[2]. It is applicable to all forms of endoscopy. The primary aim should be either to help individual endoscopists improve their technique to the desired level in a supportive way or, if appropriate, to help them decide to discontinue a technique.

Methods of identifying underperformance

Underperformance in endoscopy may in some cases be identified by the endoscopist themselves. However, it is more likely to be directly reported by others, such as patients, colleagues (including peers), allied endoscopy staff, or indirectly as a result of governance processes (e.g. complication rates). Further cases will be detected from electronic audits, such as those generated by electronic endoscopy reporting systems (e.g. Provation), or in the case of NBSP colonoscopists via the Centralised Provation Database audits. (See Table 1).

[1] Rees CJ, Thomas-Gibson S, Bourke MJ, et al. Managing underperformance in endoscopy: a pragmatic approach. Gastrointest Endosc 2018;88(4):737-44.e1.

[2] Royal College of Physicians, Joint Advisory Group on GI Endoscopy. A framework for managing underperformance and supporting endoscopists - a JAG perspective, 2019

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

Issue	Identifying underperformance	Managing underperformance
Endoscopic (technical) skills	• Local & National data collection (ERS, Centralised Provation Database for NBSP data) • Local expectation to audit against KPIs as part of NZGRS • '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. • Attendance at up skilling courses; formal evaluation using DOPS assessments.
Health	• Self-reporting and appraisal as routes to identify concerns	• Occupational health, e.g. ergonomics review / engagement with GP / use of external resources. • 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	• Would sit within the professional conduct framework, hence could be managed: ○ locally by a QA lead ○ within a directorate or

Issue	Identifying underperformance	Managing underperformance
	• Self-reporting	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 (ENTS, 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	• NZGRS as a measure of whole unit performance and standard setting	• Local and NZGRS-driven systems to define the model of a good unit and support / advice on managing this.

What to do in cases of underperformance

Endoscopy governance is the responsibility of all involved professionals, and each unit should have a named lead with overall responsibility for reviewing performance data as an integral part of the function of the Endoscopy User Group (EUG) (see NZGRS for terms of reference). If underperformance is identified, then it should be discussed with appropriate key members of the leadership team – including nursing, training, and governance leads, before discussing with the individual endoscopist (see Figure 2).

1. Identifying issues

The root cause of underperformance needs to be explored fully. These can be broadly categorised into:

- Technical
- Health
- Behavioural
- Extrinsic issues

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, e.g. patient case mix, list pressures or equipment.

2. Addressing the issues

The process should start with a confidential meeting with the endoscopist to discuss their data, to verify accuracy and validity and to discuss any mitigating or underlying circumstances. This should be conducted in a non-judgmental and empathetic manner, considering the likely stress the endoscopist will feel.

3. Working through identified issues and providing support

Managing underperformance depends on the underlying cause (Table 1) and the potential for detriment to patient care. Once clearly identified, a personalised action plan (as suggested in Figure 2) should be completed. This includes the documentation of measurable objectives and appropriate timescales for performance review, as agreed by both the clinical lead and the endoscopists (see Figure 1).

The service should be receptive to the needs of not only the endoscopist, but also to those of 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 (e.g. Directly Observed Procedural Skills, (DOPS)), either by local or external assessors (see Table 1).

4. Approaches to remediation

Failings in ***knowledge*** should be relatively easy to remedy. This can be approached by using a combination of textbooks, e-learning, library resources, observational lists, multidisciplinary meetings and specific endoscopy-orientated courses (e.g. the Sydney International Endoscopy Symposium). EGGNZ recommends that all endoscopists attend Endoscopy-containing Continuing Medical Education (CME) at least 3 yearly to remain credentialed. [3]

Substandard ***technical skills*** may require a stratified approach depending on how far below a standard the practice has fallen. For example, if caecal intubation rates (CIR) in colonoscopy have fallen to below 90%, then a discussion and review of cases may be sufficient with agreement to review KPIs in 6 months' time. If CIR falls to 85-90%, there might be a plan for the endoscopist to attend the lists of colleagues in or outside the department together with a shorter period of KPI review (e.g. 3 months). If CIR falls to 80-85% then there should be a plan for a colleague with educational training to attend the colonoscopists list for DOPS assessment and advice, viewing of approved educational material and thereafter a short review at 3 months. For CIR <80%, an immediate action plan needs to be in place and implemented which should involve suspension of independent colonoscopy along with the above approaches.

Problems in ***Attitudes, Behaviours and Judgment*** are more difficult to address. A much more bespoke approach is often required which might involve a formal Endoscopic Non-Technical Skills (ENTS) assessment (as seen on the JAG DOPS forms) or even a multi-source feedback as available through the Royal Australasian College of Physicians, RACP (https://www.racp.edu.au/fellows/resources/multisource-feedback/ways-to-complete-an-msf).

Strategies to improve performance in these domains may be via informal approaches, such as discussions with trusted senior colleagues, a mentor, the lead endoscopist, clinical director or director in order to formulate an agreed outcome. Or they may be more formalised, perhaps with the help of the human resources department if the severity of problems might require suspension or dismissal.

[3] The Endoscopy Guidance Group for New Zealand, Guidelines for Local Credentialing in Adult Endoscopy, 2018

5. Mentorship.

An endoscopist in difficulty may be greatly assisted through what can be an immensely stressful time by a suitable mentor.

One definition of a mentor is someone who provides an enabling relationship that facilitates another's personal growth and development. The relationship is dynamic, reciprocal and can be emotionally intense. Within such a relationship the mentor assists with career development, and guides the mentee through organisational, social and political networks[4] . A mentor can be thought of as a trusted counsellor and guide.

To some degree, informal mentoring is an intrinsic part of the professional working practice in a team-based environment. Endoscopists interact with peers and colleagues on many levels, and so facilitate self-assessment, team building and developing new skills. Often this mentor is chosen by the endoscopist themselves. Formal mentoring is when the mentor is allocated to the employee. This carries the risk that it will be resented, time wasting, ineffective and ultimately unsuccessful.

A failing endoscopist will often feel threatened, vulnerable, and unhappy and be aware of their shortcomings. They will therefore need support through the remedial process. This can be provided by a mentor who;

- is known to the endoscopist and liked by them – a role model
- is geographically close
- has specialist knowledge in the area of concern, and who understands and practises GI Endoscopy in New Zealand,
- has mentoring experience
- has time for the task
- is NOT part of the endoscopists directorate
- can access required remedial facilities
- is accepted by management of the Endoscopy Unit
- is chosen by the endoscopist themselves

The role of mentor should not be taken lightly. There is a useful guide to mentoring produced by the University of Auckland, which we recommend both parties read before entering into this relationship[5] .

Governance Process

Good governance of quality is crucial to dealing with the efficient and safe running of endoscopy services. The NZGRS supports the Endoscopy User Group (EUG) as the forum for governance of all endoscopy quality, including the identification of underperformance and development of local processes for underperformance management. These processes should be agreed by the EUG and made available to all the Endoscopy unit employees. Endoscopy units employ clinicians from many departments that have different governance structures, and these should be consulted with (see Figure 2).

Integral to good governance is quality assurance. Endoscopy units engaged in the National Bowel Screening Programme are mandated to participate in the National Quality Improvement Programme

[4] Queensland Government -A Mentoring Framework, 2006
[5] The University of Auckland – A Guide to Mentoring, 2014

with biannual service assessments and data submission to the NZGRS https://nz.jagaccreditation.org. Support for endoscopy quality improvement is provided by the NEQIP team (NEQIP@hbdhb.govt.nz).

Conclusion

All endoscopy units, perhaps more especially those involved in continuous quality improvement, will undoubtedly encounter underperforming staff. It is recognised that a significant proportion of newly- certified colonoscopists exhibit a drop in performance during recent independent practice, but it should be recognised that all endoscopists, whether in difficulty or meeting performance targets, would likely benefit from the routine practice of self-auditing, mentoring and coaching.

Fostering a learning and sharing environment for safety and quality (as supported by the NZGRS), as well as providing support for endoscopists when needed, are imperative steps to delivering a high-quality endoscopy service.

Acknowledgements

Thanks to Chris Healey, Keith Siau, Geoff Smith and Siwan Thomas-Gibson (JAG UK) for allowing us to reference their document and giving us permission to use their tables and figures. Thanks also to Dr Jim Brooker for an external review of this paper.

Abbreviations

CCRTGENZ	Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy New Zealand
CME	Continuing Medical Education
CPD	Continuing Professional Development
DOPS	Direct Observation of Procedural skills
EGGNZ	The Endoscopy Guidance Group for New Zealand
ENTS	Endoscopic Non-Technical Skills
ERS	Endoscopy Reporting System
EUG	Endoscopy Users Group
GESA	Gastroenterological Society of Australia
JAGUK	Joint Advisory Group on GI Endoscopy UK
KPI	Key Performance Indicator
MSF	Multi-Source Feedback
NEQIP	National Endoscopy Quality Improvement Programme
NBSP	National Bowel Screening Programme
NZGRS	New Zealand Global Rating Scale
QA	Quality Assurance
QI	Quality Improvement
PDP	Personal Development Plan

Resources:

1. The Medical Protection Society runs a number of risk management workshops, such as "*Mastering Professional Interactions'* which may have relevance to endoscopists in difficulty. [https://www.medicalprotection.org/newzealand/events-e-learning/workshops/workshops/nz-mastering-professional-interactions-workshop].
2. Guidance on Mentorship. https://cdn.auckland.ac.nz/assets/auckland/business/current-students/PDFs/mentoring-guide-final.pdf
3. The National Endoscopy Training Initiative of the Gastroenterological Society of Australia (GESA) allow access to their courses, such as the '*Practical Quality Colonoscopy Skills Workshops'*. https://www.gesa.org.au/education/neti/
4. Ways to complete a MultiSOurce Feedback, RACP https://www.racp.edu.au/fellows/resources/multisource-feedback/ways-to-complete-an-msf
5. Siau K, Hodson J, Valori RM, et al. Performance indicators in colonoscopy after certification for independent practice: outcomes and predictors of competence. Gastrointest Endosc 2019;89(3):482-92.e2.

References:

Getting It Right First Time (GIRFT). [cited 23rd September 2019]; Available from:

https://gettingitrightfirsttime.co.uk/

Gawande A. Want to get great at something? Get a coach. 2017 [cited 30th April 2019];

Available from: https://www.ted.com/talks/atul_gawande_want_to_get_great_at_something_get_a_coach?language=en.

Rees CJ, Koo S, Anderson J, et al. British society of gastroenterology Endoscopy Quality

Improvement Programme (EQIP): overview and progress. Frontline Gastroenterology 2019;10(2):148.

Rees CJ, Thomas-Gibson S, Bourke MJ, et al. Managing underperformance in endoscopy: a

pragmatic approach. Gastrointest Endosc 2018;88(4):737-44.e1.

Royal College of Physicians, Joint Advisory Group on GI Endoscopy. A framework for managing underperformance and supporting endoscopists - a JAG perspective, 2019

Queensland Government - A Mentoring Framework, 2006

The Endoscopy Guidance Group for New Zealand, Guidelines for Local Credentialing in Adult Endoscopy, 2018

The University of Auckland – A Guide to Mentoring, 2014

Thomas-Gibson S, Barton JR, Green J, et al. Mentoring and Quality Assurance of screening endoscopists within the NHS Bowel Cancer Screening Programme. NHS Bowel Cancer Screening Programme (Publication No. 10), 2013.

Thomas-Gibson S, Matharoo M, Siau K, et al. PTH-044 Improving safety and reducing error in endoscopy (ISREE) – a JAG initiative. Gut 2018;67(Suppl 1):A34.

Figures

Figure 1: Proforma recommendations for documenting action plans for managing underperformance in endoscopy

Date of meeting				
Clinical lead			MCNZ/NCNZ no	
Endoscopist			MCNZ/NCNZ 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				

Figure 2: EGGNZ Framework for managing endoscopists in difficulty.