The Endoscopy Governance Group for New Zealand Workshop

Wednesday 6 September 2017

Auckland Airport

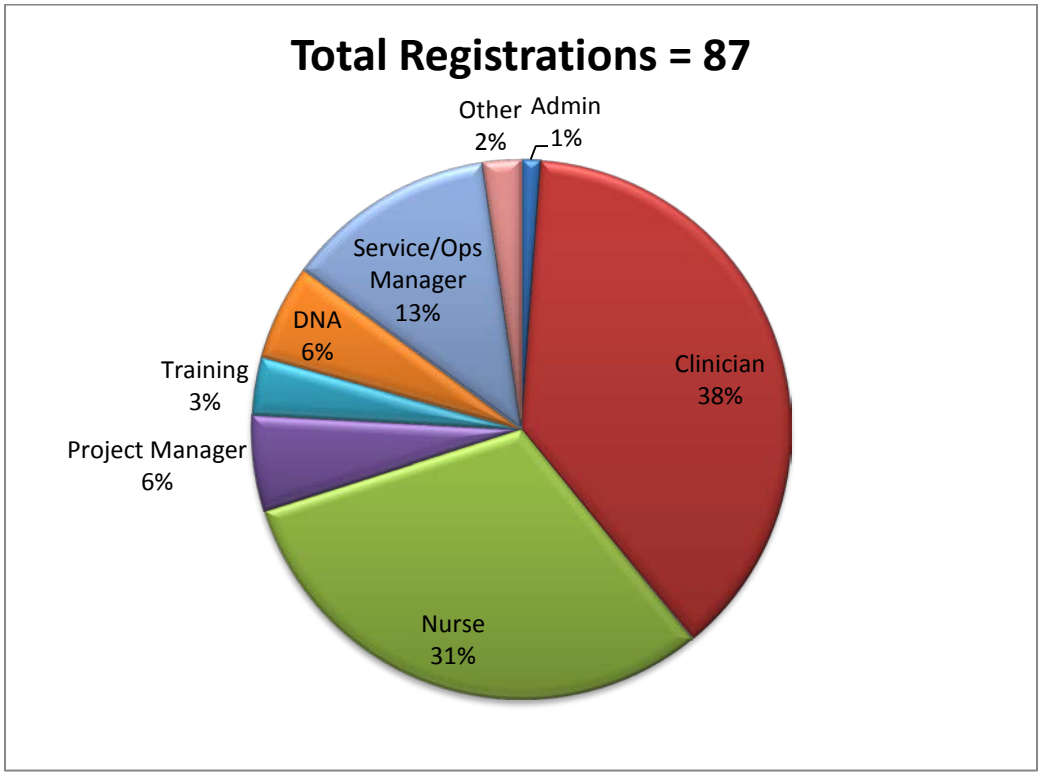
Introduction

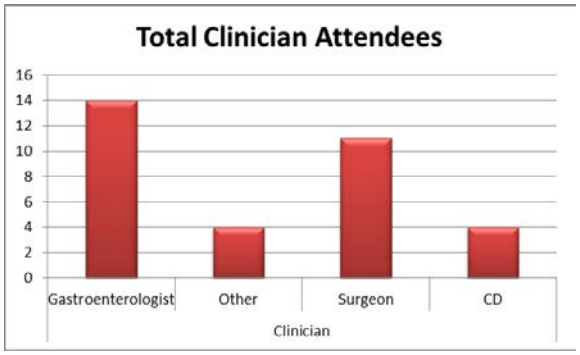
The aim of the workshop was to facilitate understanding of the processes and needs in endoscopy units to provide quality endoscopy for New Zealand.

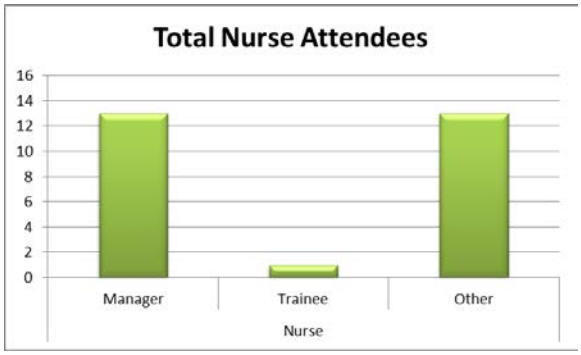
The Endoscopy Governance Group for New Zealand (EGGNZ) was established in 2015 by endoscopy clinicians in response to a need for a national endoscopy governance structure; as highlighted by NEQIP and the Sapere (2015) report on 'Governance of endoscopy quality and related initiatives'. The first year was spent engaging stakeholders, developing Terms of Reference, Memorandum of Understanding and establishing a working group to produce 2 sets of standards; 'Endoscopy Standards for Individual Colonoscopists in Performing Bowel Cancer Screening in New Zealand' and 'Endoscopy Unit Standards for performing Bowel Cancer Screening in New Zealand'. The standards are now completed and have been made available in electronic and hard copies to attendees at the workshop and other interested parties.

The workshop aimed to demonstrate the work EGGNZ and NEQIP have been doing over the last 12 months and review the issues which are currently being faced by endoscopy in New Zealand and which will likely effect endoscopy for the next few years.

The event was well attended with 82 attendees from across New Zealand with at least one representative from each of the DHBs. In addition, there were representatives from several private endoscopy units, the regional cancer networks and the Ministry.







We requested feedback from the attendees with 29% of the surveys returned. The breakdown of responses reflected the make-up of attendees, although not all DHBs responded to the survey. People responding to the survey were asked to identify their roles and the location they worked in.

90% of people felt that the meeting fulfilled their reason for attending and that the quality and content of the presentations was good. The majority of people would attend a similar event in the future.

Meeting Overview

Session 1: Understanding Training in Endoscopy – Chair Russell Walmsley

FRACP NZ perspective	Paul Frankish
RACS perspective	Rowan French
A training curriculum proposal	Russell Walmsley
Nurse Endoscopy training	Jacky Watkins/Alan Fraser
Training experiences other practitioners	Caroline Ryan
	Alex Wittig

The first 3 presentations covered the training curriculum for RACP and RACS and offered a comparison with the Tim King curriculum discussion paper. Both RACS and RACP have reviewed their curriculum based on the document. The RACP curriculum can appear to be Australian centric as it prioritises private and office based training and endoscopy. There have been difficulties for the NZ arm of RACP to break down the issues as the advanced training committee in Australia is reluctant to take on the responsibility of co-ordinating an endoscopy training programme - they defer to the conjoint committee and GESA. There are differences between the training programmes as many surgical trainees have no endoscopy sessions in their current rotations but physician trainees are expected to have 2 training lists per week. There needs to be a consistent approach.

There are resource requirements to provide quality training which are not available including space to run training lists and appropriately trained trainers. Currently, endoscopy training is being provided in many centres by trainers who have no formal training. There was support in the room to re-establish train the trainer courses.

Conscious sedation was identified as a key issue for NZ practitioners as, unlike Australia, there is rarely an anaesthetist present at these procedures. EGGNZ have highlighted this issue and intend to work with NZ Society of Anaesthetists to provide a NZ specific non-anaesthetist conscious sedation training document. The Auckland University Nurse Endoscopy course was presented in a short video by Alan Fraser See also Appendix 1 (. There has already been some training in conscious sedation on this course; this needs to be reviewed further by the nursing council. The nurse endoscopy course includes 2 dedicated training lists per week initially in gastroscopy and extending in to colonoscopy with increasing experience. There are currently 4 nurses on the course and they should be competent for independent gastroscopies within 12-18 months with a second cohort of 4-5 candidates to be recruited for the 2018 intake.

The experiences of an overseas physician and GP practitioners in NZ were related. Unfortunately this has not been a particularly positive experience as there is no regulated system in place to ensure consistent training or recognition of overseas experience. More work needs to be done to support training lists

across the country but this can cause issues with resource availability in already oversubscribed endoscopy services.

There is support from all that trainees should be assessed based on competency and not volume of work done and that this should be applied consistently across all the professional groups.

Key Points

1. The training curriculum for RACS and RACP are based largely on Tim King's curriculum and should be used to develop NZ based training programmes
2. Should there be a consistent curriculum for all endoscopy trainees, including nurse endoscopy?
3. There is insufficient sedation training for NZ non-anesthetist practitioners EGGNZ will approach NZ Society of Anesthetists to develop an appropriate programme.
4. Certification should be based on competency not volume of procedures performed.

Session 2: Understanding Certification and Recertification – Chair Richard Stein

Standards in endoscopy	Russell Walmsley
Current system for recognition of training in NZ	Marianne Lill

EGGNZ have worked over the last 12 months to develop national standards for colonoscopy in the Bowel Screening Program. The standards employ 3 key concepts

1. Quality Standards which are measurable and have recognised *Key Performance Indicators (KPIs)*
2. Auditable Outcomes which are measurable items for which there are no defined *KPIs*
3. Practice Guidelines which are items that are not suitable for measurement but contribute to uniformity of good practice.

The key areas of note are:

1.	Adenoma Detection rates	**Quality Standard:** ADR>35%
2.	Withdrawal Times.	**Quality Standard:** ≥ 6 minutes in >90% of non-interventional cases
3.	Caecal Intubation Rates	**Quality Standard**: >90% of intact colons
4.	Scheduling & Experience	**Auditable Outcome**: No more than 5 cases per 4 hour list
5.	Procedural techniques	**Practice guideline**: Retroflexion should be attempted MINIMUM picture set of appendiceal orifice AND either caecum with IC valve or terminal Ileum
6.	Bowel Preparation	**Auditable outcome:** Boston Bowel Prep Score ≥6, with no segment <2, in >90%

At Waitemata the withdrawal times are recorded for all endoscopists on a 3 monthly basis. Not all are achieving the >90% target. The trends in withdrawal times will be monitored to demonstrate any improvements.

Again, general support for standards, KPIs and quality improvement but there were concerns raised around resourcing.

Current recognition of training for college trainees in NZ is overseen by the conjoint committee, of which Marianne is the chair. The recognition of training relies on a trust based system of logbook, references and basic KPIs. This system does not certify competence. The current system works well for trainees within a training programme but does not work well for overseas training, historical training or non-traditional groups, as we also heard in the first session.

NZ does not currently have a central system for certifying competence in endoscopy. This is done at the local level through the credentialing process by individual hospitals with no agreed national standard. Implementation of bowel screening has created the need for national standards, with one standard for all endoscopy including bowel screening. An ideal certification system would include:

- Agreed, evidence based KPIs compatible with other countries
- Simple measurement system/s that do not require (much) extra work
- 100% reliable and verifiable data
- Cheap to administer
- Inclusive for all groups
- No-fault system for remediation of non-performers
- Include cognitive component/ongoing learning

Representatives from Health Workforce New Zealand were present at the meeting and are interested in any solutions which could be suggested for the training issues and what could be done differently – Answers on a postcard to the usual address: jan.tew@nra.health.nz

Key Points

1. Some of the KPIs included in the EGGNZ standards documents are more lenient than other standards. This is a working document and will be reviewed based on the outcomes of the Waitemata Bowel Screening Pilot data.
2. A reasonable number of scopes are required to demonstrate KPIs; the volume alone is not an indicator for competency.
3. NZ needs an agreed certification and re-certification process

Session 3: Quality in Endoscopy Units

Understanding the NZGRS	Sherry Sharp
Results of the March 2017 Census	Malcolm Arnold
Unit Accreditation	Russell Walmsley

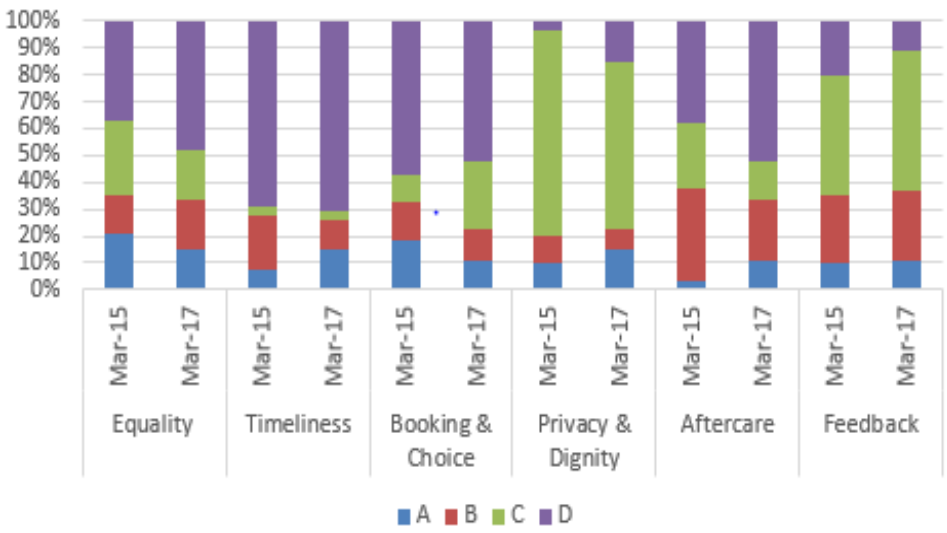
48% of survey responses felt this was the most valuable session closely followed by session 2.

NEQIP was launched in NZ in 2011. The programme was supported by the Ministry and saw and consistent improvement in endoscopy quality until it stopped operating in 2015. In 2016, NEQIP was re-established under a new team and the census reports reintroduced in 2017. The data from these surveys shows a drop in quality over the intervening 2 years with endoscopy unit support to refocus on quality based on the NZGRS (New Zealand Global Rating Score) standards

NZGRS is a web based, self-assessment QI tool. The units score themselves against several items per standards (see table below) and the attributes levels D through to A and can then be monitored over time to demonstrate progress. Compared with 2015 the number of 'A' levels has dropped for some domains and the number of D's has increased.

1.	**Clinical quality**	**2.**	**Quality of the patient experience**
1	Information/Consent	1	Equality of access
2	Safety	2	Timeliness
3	Comfort	3	Choose and book
4	Quality	4	Privacy and dignity
5	Appropriateness	5	Aftercare
6	Results to referrer	6	Patient feedback
3.	**Workforce**	**4.**	**Training**
1	Skill mix review and recruitment	1	Environment and opportunity
2	Orientation and training	2	Endoscopy trainers
3	Assessment and appraisal	3	Assessment and appraisal
4	Staff are cared for	4	Equipment and materials
5	Staff are listened to		

It was noted a drop in the 'A' rating in the equality domain from 2015 – 2017 (see fig below). An example of equity of access was addressed by WDHB as part of the Bowel screening pilot. They noted that a specific effort was made to recruit Maori and Pacific Islanders to the screening programme. This dedicated piece of work involved 4 attempts to contact participants with at least one taking place out of normal working hours. Whilst this was a resource heavy solution in did demonstrate a significant increase in participation rates.



The key to success is good clinical leadership and to achieve this all DHBs should establish an Endoscopy User Group (EUG)

Further support of quality in endoscopy units should come from unit accreditation. Other healthcare units in NZ are accredited by an external organisation (International Accreditation New Zealand [IANZ]), including pathology and radiology.

To achieve consistent standards and support quality improvement, NZ should adopt unit accreditation. EGGNZ has scoped accreditation options which included EGGNZ, JAG (UK) or IANZ/other third party provider.

Key Points

1. Quality Endoscopy -
   A **proven** competent endoscopist working with a **proven** competent team in an accredited unit (competence/quality having been assessed against recognised standards)
2. A major step in quality improvement is to ensure each unit has an Endoscopy User Group, ensure all census questions are answered honestly and plan your QI work for each 6 months.
3. Equality is an essential aspect of NZGRS. Waitemata DHB shared a need for dedicated resource to ensure adequate Maori and Pacific Island engagement in the Bowel Screening Pilot.
4. Unit accreditation will support NEQIP and the implementation of NZGRS

Session 4: Understanding the Endoscopy workforce

NZ workforce prediction model	Emmanuel Jo
NZSG survey results	Malcolm Arnold

Health Workforce NZ (HWNZ) presented their workforce prediction model to demonstrate patterns of working including age, scope, ethnicity, entry and exit from the workforce and working hours etc. They have been able to model people entering, exiting and re-entering the workforce.

Based on 2016 data the model can predict the number of gastroenterologists and surgeons available up to 2025. Although the data shows gastroenterologists the predicted exit and re-entry for this group is based on internal medical specialists with manual adjustment for the changes in gastroenterologists seen in the last 3 years for each age group.

This suggests 268 surgeons in 2016 leads to 280 in 2026 and 74 gastroenterologists will give rise to 101 by 2026.

The NZ Society of Gastroenterology (NZSG) commissioned its own audit and the results suggest a discrepancy in the number of endoscopists compared with the HWNZ data. Further review of this data is required to give a clearer picture of what this means.

Key Points

1. The NZSG survey results are needed to provide comparison to the HWNZ data.

Conclusion

National awareness of NEQIP and the role of EGGNZ are vital. The workshop aimed to raise awareness of EGGNZ and the national standards developed by the group. The documents were circulated at the meeting and electronic versions circulated as requested.

EGGNZ will work with stakeholders at a national level to further promote their role including at the NZSG ASM and with the development of an EGGNZ website to host the standard documents.

The key areas of development for EGGNZ for the next 3 years are given below, ranked in the order identified in the survey:

1. Recognition or certification of training for all endoscopists
2. Development of a sustainable funding model for quality endoscopy improvement in NZ
3. Set endoscopy standards for all endoscopy procedures

4. Accreditation of existing units based on the NZGRS standards
5. To assist in developing Endoscopy Training Courses to support NZ-specific endoscopy training needs
6. Recertification of existing endoscopists

In general the feedback from the meeting attendees agrees with these priorities with one additional priority for consideration of the steering group, which is:

- 'Accreditation of Nursing and reprocessing staff as part of the NZGRS'

Thanks to everyone who was involved in making this event a success especially the presenters. We also appreciate the support of the DHBs in supporting EGGNZ with such excellent attendance.

EGGNZ
The Endoscopy Governance Group for New Zealand

Appendix 1: Nurse Endoscopy Course Update

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

MEDICAL AND HEALTH SCIENCES
SCHOOL OF NURSING

NURSE ENDOSCOPY TRAINING UPDATE

CURRICULUM

Pre-requisites

Academic: Postgraduate diploma including: advanced assessment and diagnostic reasoning, anatomy and pathophysiology (gastro-intestinal system focus) and pharmacology leading to nurse prescribing.

Professional experience: Minimum of 5 years clinical experience post registration and 3 years in Gastroenterology/Endoscopy or related areas such as colo-rectal surgery.

Academic curriculum

Set and assessed by the University of Auckland. The program consists of two core papers:

- Gastrointestinal disease management
  - Up-skill consultative skills for potential nurse specialist clinics
- Knowledge and skills for Gastrointestinal Endoscopy including:
  - Anatomy, pathophysiology and visual recognition skills
  - Introduction to endoscopy (simulation learning)
  - Procedural sedation (simulation learning)

RECOMMENDED EXPOSURE

Work-based training using formative direct observation of practice (DOPs): 2 x 8 point lists per week approximately 2 years.
Health Workforce NZ funding available to support academic and work based training.

ASSESSMENT

Local assessment by at least two independent expert practitioners using summative DOPS x4.
Log book, DOPs assessments, assessor expert global evaluation and Nursing Council New Zealand competencies submitted as a portfolio to DHB Registered Nurse Expanded Practice and Credentialing Committee as per Nursing Council New Zealand legal requirements.
Portfolio and competencies repeated on three yearly cycle for continued competence.

EXPECTED NUMBERS OF SCOPES

At least 200 unassisted complete examinations independently but with supervision before considered for summative assessment of competence for gastroscopy or colonoscopy including biopsy, polypectomy etc.

NUMBERS OF TRAINEES IN NZ

Four trainees, one will focus of flexible sigmoidoscopy and colonoscopy. Three or four trainees expected in 2018.

HOW ADVANCED ENDOSCOPY IS LEARNT

N/A

DO TRAINEES DO ENDOSCOPY FELLOWSHIPS

N/A

CHANGES ON THE HORIZON

Prescribing for sedation: Currently under standing orders when assessed as competent.
Work continues to add Endoscopy and Procedural sedation to the list of specialities for designated prescribing. Extensive training including theory and simulation learning currently provided by anaesthetists as well as mentoring over at least 2 years to support safe practice.

Postgraduate Nursing Endoscopy – 2018

A pathway for postgraduate study for Registered Nurses.

A three step qualification approved by Nursing Council of New Zealand

- each step ends in a qualification, can be followed by a pause or leads on directly to the next.
- B Grade Average (GPA5) needs to be achieved to progress on to Masters.

Postgraduate Certificate in Health Sciences

60 points – 2 years part-time

Recommended* Courses

NURSING 773	Advanced Assessment and Clinical Reasoning Every Semester. 5 Study days online material and clinical exam	30 pts
NURSING 742	Biological Science for Practice Every Semester. Online Delivery.	30 pts

60 pts

Postgraduate Diploma in Health Sciences

Advanced Nursing 60 points – 2 years part-time

Recommended* Courses

Alternative course options are available. Please seek course advice. Choose 60 points.		
NURSING 785	Clinical Reasoning in Pharmacotherapeutics	30 pts
NURSING 746	Evidence-based Practice and Implementation	30 pts

120 pts

Master of Nursing

120 points

Please seek course advice to complete remaining 60 points in Master of Nursing.		
NURSPRAC 715	Endoscopy Nursing	30 pts
NURSING 744	Endoscopy Nursing Practicum	30 pts

240 pts

*A range of courses may also be taken to complete MN and all students are encouraged to seek academic advice about course changes/options that reflect personal preferences.
If completing a Master of Nursing with a Thesis or Research Portfolio, then a research course is a prerequisite.

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NEW ZEALAND

MEDICAL AND HEALTH SCIENCES
SCHOOL OF NURSING

Contacts for information about...

Courses: Louise Carrucan-Wood | l.carrucan-wood@auckland.ac.nz
Endoscopy Nursing: Jacky Watkins | j.watkins@auckland.ac.nz
Enrolment: Anna Sale | a.sale@auckland.ac.nz
Courses, course dates: www.fmhs.auckland.ac.nz/son

All of our courses lead to qualifications that are approved by the Nursing Council of New Zealand and therefore are eligible for funding by Health Workforce New Zealand.

Contact your local DHB HWNZ Co-ordinator.

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