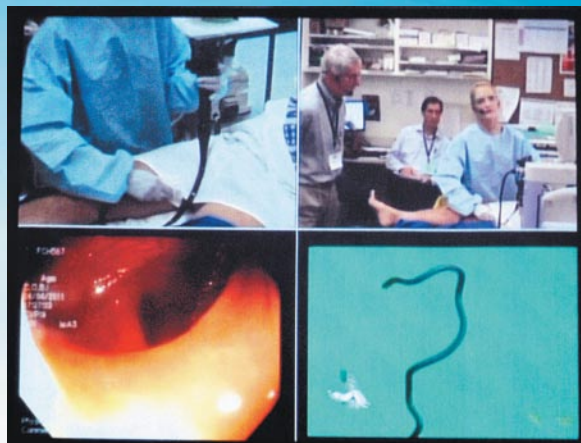


FINAL REPORT

Towards a National Approach to Training and Certification

Improving the Quality of Colonoscopy



June 2011

**NATIONAL
BOWELCANCER**
SCREENING PROGRAM



Report for the Department of Health and Ageing

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EXECUTIVE SUMMARY

This Project has been carried out by the Gastroenterological Society of Australia (GESA) during the period 2008 to 2011, supported by the Australian Government as represented by the Department of Health and Ageing. Its purpose has been to improve the quality of colonoscopy in Australia by developing a national approach to training of colonoscopists, and their certification and re-certification.

The achievements of the Project are as follows:

1. Training of Colonoscopists

- (a)** Developing a colonoscopy training curriculum, informed by literature reviews and the findings of a parallel Commonwealth-funded project carried out at the University of Queensland.
- (b)** Establishing the National Endoscopic Training Initiative (NETI), under the aegis of the Australian Gastrointestinal Endoscopy Association and GESA, to set standards for individual endoscopists and training in endoscopy, and to provide Australia-wide support for the endoscopy workforce. An important part of its functioning has been the support of training in colonoscopy.
- (c)** Establishing high quality Train-the-Colonoscopist Trainer courses. These 2-day advanced courses, aimed at giving educational skills to key trainers as well as ensuring that their own technical skills are at the highest level, have been run nationally since 2008. To date, more than 60 specialist trainers have completed the courses.
- (d)** Developing Introductory, Basic and Advanced Courses and Workshops for trainees in colonoscopy. To date, more than 300 trainees have completed these courses nationally. The feedback from both trainees and trainers has been highly positive.
- (e)** Broadening the methods of training by purchasing (from the Project's budget) and deploying computerised training aids (ScopeGuide™) across Australian training centres.

2. Certification and Re-certification of Colonoscopists

(a) Initial certification: During the Project, the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) has streamlined and improved its processes for certifying competence in colonoscopy at the completion of training. It has done this by (i) moving from endpoints that were primarily based on numbers of procedures completed to endpoints that also require improved certification by supervisors of competence to perform procedures unaided, and (ii) the introduction of an online web-based rather than paper-based recording of training experience and competence. The CCRTGE has the support of all key stakeholders, and is composed of representatives of the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians, the Colorectal Surgical Society of Australia and New Zealand and GESA.

(b) Re-certification: Standards and procedures for periodic re-certification of competence in colonoscopy have been developed by a broadly-based committee of stakeholders, including colorectal surgeons, rural and regional specialists and gastroenterologists. It has commenced to trial the re-certification standards and processes. Based on the evaluation of the pilot studies, further changes will be made if needed. Live deployment of voluntary re-certification in colonoscopy (over a rolling triennium) is expected to commence in 2012.

3. Achieving Sustainability with a Self-Funding Model

Data obtained during the Project – on participation rates and their upward trends, and on the costs associated with each phase – have now given a firm basis for developing the budgetary model for ongoing self-funding. Income will be derived from fees charged to trainees for the various training courses, and fees to trained colonoscopists for maintaining their records on the certification and re-certification registers.

In conclusion, as a result of the Project, training of colonoscopists in Australia has been greatly benefitted, certification has been improved, and voluntary re-certification with support of stakeholders will soon commence.

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ABBREVIATIONS

AGEA	Australian Gastrointestinal Endoscopy Association (AGEA)
AHMAC	Australian Health Ministers' Advisory Council
CCRTGE	Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy
CCRC	Conjoint Committee for Recertification in Colonoscopy
CSSANZ	Colorectal Surgical Society of Australia and New Zealand
DoHA	Department of Health and Ageing
DOPS	Direct Observation of Professional Standards
FOBT	Faecal Occult Blood Tests
GENCA	Gastroenterological Nurses College of Australia
GESA	Gastroenterological Society of Australia
GI	Gastrointestinal
GSA	General Surgeons Australia
GP	General Practitioner
JAG	Joint Advisory Group on GI Endoscopy
JETS	JAG Endoscopy Training System
MoPS	Maintenance of Professional Standards
NBCSP	National Bowel Cancer Screening Program
NETI	National Endoscopy Training Initiative
NHMRC	National Health and Medical Research Council
QWG	Quality Working Group
RACP	Royal Australasian College of Physicians
RACS	Royal Australasian College of Surgeons
TCT	Train-the-Colonoscopist-Trainer

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1. BACKGROUND

Colorectal cancer is a major cause of death in the western world and is currently the second most common cause of death from malignant disease in Australia. It is one of the most curable types of cancer if found early. Screening improves early detection and treatment.

The objective of the National Bowel Cancer Screening Program (NBCSP) is to reduce the mortality and morbidity associated with bowel cancer through early detection and prevention.

The availability of high quality video colonoscopy is a central tenet in the investigation of symptomatic patients with bowel disorders, and is an integral component of the NBCSP.

Implementation of the NBCSP requires that all aspects of the screening pathway, in particular colonoscopy services for the assessment of positive Faecal Occult Blood Tests (FOBTs), will be effective, efficient, equitable and evidence-based.

The NBCSP pilot program was initially introduced without extra funding for colonoscopy service improvement or provision for the increase in colonoscopic demand resulting from the introduction of the NBCSP. Feedback from the pilot program highlighted a number of issues. Recommendations for improvement of NBCSP effectiveness and efficiency, with respect to colonoscopy, included:

1. The need for improved colonoscopy training for trainees and refresher courses for existing proceduralists to improve completion rates, polyp and adenoma detection and removal, and detection of flat or depressed lesions.
2. Introduction of colonoscopy training initiatives for trainees that aligned with NBCSP colonoscopy indicators such as caecal intubation, withdrawal time and adenoma detection rate.
3. Introduction of standardised, interdisciplinary colonoscopy training to reduce apparent differences between specialties with regard to compliance with guideline recommendations, completion rates and quality of polypectomy.
4. Improved quality of colonoscopy training by adoption of a UK-style training program with centres of excellence incorporating newer, more objective assessment methods, the use of a variety of tools such as simulation, and rotations of trainees between metropolitan, rural, public and private sector training facilities.
5. Incorporation of NHMRC guidelines into colonoscopy information systems to improve documentation, provide guideline recommendations at the point of care, enhance the use of gastroenterology nurse coordinators to facilitate compliance with guidelines and provide guideline-based colonoscopy referral letters for GPs.
6. Provision of information and education about the NBCSP and bowel cancer risk factors, including family history and polyp surveillance guidelines, for participants, GPs and proceduralists.

Overall, the need to introduce a co-ordinated national approach to the training and maintenance of skills for colonoscopists, and the institution of a system for the recognition of this training became urgent.

Subsequently, the Quality Working Group (QWG) was asked by the Australian Health Ministers' Advisory Council (AHMAC) to provide advice on strategies to improve the quality, consistency and availability of colonoscopy services in Australia.

The Gastroenterological Society of Australia (GESA) is the peak professional body for gastroenterology and hepatology in Australia. GESA sets, promotes and continuously improves the standards of practice, training and research in gastroenterology in Australia. GESA has over 1000 members and is the chief advocacy group for the healthcare professionals and scientists working in this field. The Australian Gastrointestinal Endoscopy Association (AGEA), whose members are involved in the training and supervision of trainees in gastroenterology, is a division of GESA. In addition GESA provides the infrastructure and administration for the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE). GESA also manages and administers the National Endoscopy Training Initiative (NETI).

GESA members were subsequently involved in the NBCSP Advisory Committee and the QWG.

GESA was granted funding from the Department of Health and Ageing (DoHA) to undertake the project **Towards a National Approach to Training and Certification aimed at Improving the Quality of Colonoscopy**. The project commenced in May 2009.

The QWG recommendations included specific reference to skills training, certification and the development and introduction of a formal process to ensure the initial and ongoing competence of colonoscopists.

GESA used a control point identification chart model to manage the project, and reported to the QWG at each meeting during the length of the project. A summary of the project schedule at 30 April 2011 is included in [Appendix 1](#).

A summary of the tasks and the associated activities completed by GESA is provided in this Final Report.

2. ACHIEVEMENTS

A. BEST-PRACTICE COLONOSCOPY TRAINING

The quality and safety of patient care in colonoscopy has been improved by defining and improving the standards and methods by which colonoscopy is trained, assessed and practised in Australia.

i. National Endoscopic Training Initiative (NETI)

To enhance the quality and safety of colonoscopy and coordinate colonoscopy training in Australia, The Gastroenterological Society of Australia (GESA) and the Australian Gastrointestinal Endoscopy Association (AGEA) established the National Endoscopic Training Initiative (NETI).

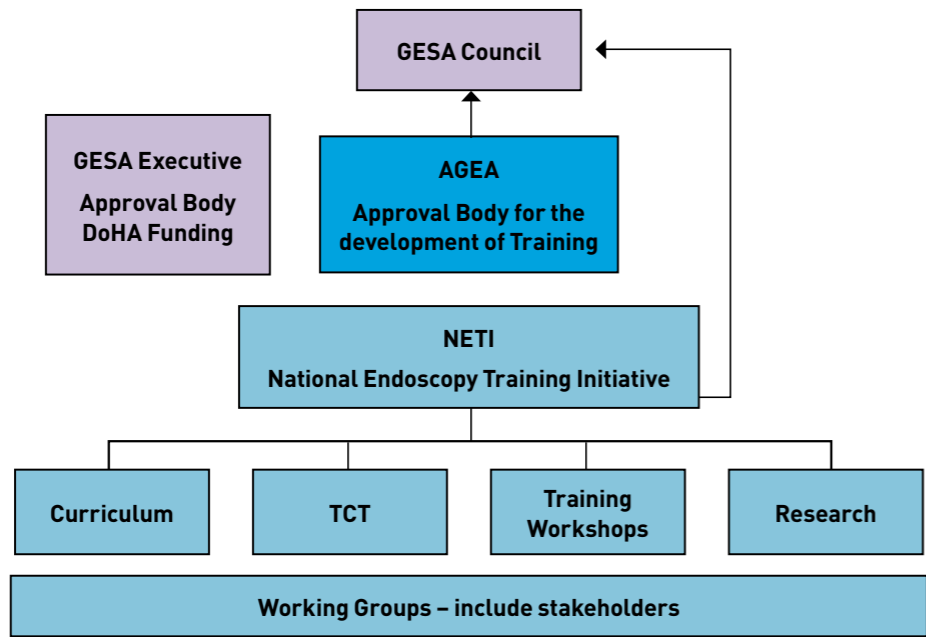
NETI has set up a comprehensive series of national, formalised and standardised colonoscopy workshops conducted by high quality trained supervisors.

NETI has set *standards* for individual endoscopists and for the conduct of training in endoscopy. Aimed at physician and surgeon endoscopists and trainees, NETI provides Australia-wide *support* for the endoscopy workforce to ensure they have the skills, resources and motivation necessary to deliver high quality, patient-centred care in a timely manner.

NETI Structure and Governance

NETI is established as a committee of GESA under the Society’s By-laws, with physician and surgeon representatives. The NETI Chair reports to the GESA Council.

Fig 1: NETI Organogram



NETI is serviced by the administrative staff of GESA. Support and direction for the tasks and activities are provided by the lead representative from each stakeholder, using the outline of the project plan and timelines set out and agreed to at the commencement of the project.

NETI Outcomes

The NETI steering committee established or refined:

- The training model for colonoscopy
- The development of a curriculum
- The training methods and their delivery.

OBJECTIVE	OUTCOME	LEAD
TRAINING		
Provide access to training for specialists who teach colonoscopy to improve their teaching skills.	Train the Colonoscopist Trainer (TCT) interactive workshops	Dr. Cameron Bell
Produce courses, evidence-based syllabus and self-funding curriculum which is coordinated and multi-disciplinary to ensure consistency in the approach to colonoscopy training and service provision across Australia.	NETI Curriculum for Colonoscopy Training	Dr. David Hewett
Commence implementation of the national model for training in colonoscopy across Australia.	Implementation of accessible and cost-effective, best-practice NETI Train-the-trainer, Basic and Introductory Courses/ Workshops	Dr. Gregor Brown Dr. David Hewett Dr. Michael Bourke

ii. NETI: World Class Best Practice-Colonoscopy Training

Quality Patient-centred, Best Practice and Evidence-based Training

GESA and NETI have ensured a robust, quality training framework for endoscopy professionals. The training is based on current evidence of best-practice to make decisions about the care of individual patients and the delivery of cost-effective health services.

Clinical evidence from systematic research was integrated with practical clinical expertise. Up-to-date information from relevant, valid research about bowel cancer detection, national and international screening programs, colonoscopy procedures, sedation practices, infection control guidelines and quality indicators was obtained and evaluated.

Consultation and Contribution

In an Australian-wide, self-completed survey of colonoscopy trainers and trainees, approximately 70% of trainers supported a UK-style colonoscopy training model within dedicated accredited training centres using a variety of training approaches including simulation.

Improvements to the previous training model suggested by trainees included a greater use of simulation, training tools, a more UK-style training course, concentration on quality indicators, increased access to training lists, accreditation of trainers and interdisciplinary colonoscopy training.

Based on the feedback, GESA and NETI consulted with numerous international leads, and utilised the services of the Joint Advisory Group (JAG) on GI Endoscopy from the United Kingdom.

The UK National Endoscopy Programme is held in high regard. The JAG was established in 1994 under the auspices of the Academy of Medical Royal Colleges (AMRC). The JAG Committee is an executive board, responsible for agreeing and setting policy and strategy and advising its constituent bodies and other significant organisations (such as the National Health Service [NHS]) on standards and quality in GI endoscopy. The JAG provides a forum for gaining professional consensus and agreement on standards in endoscopy. It also advises on suitable processes and frameworks to quality-assure and enhance those standards. The Committee is supported by three Quality Assurance Working Groups and is based at the Royal College of Physicians of London, UK.

Where appropriate, elements of the JAG program and other international programs were incorporated into an Australian based curriculum.

In response to stakeholder consultations with non-medical personnel, a draft of suggested pathways for undertaking the necessary education and training was also completed [\(Appendix 2\)](#).

Consultations were also conducted with the Gastroenterological Nurses College of Australia (GENCA). GENCA produced a position statement on nurse endoscopists [\(Appendix 3\)](#).

NETI National Model for Training in Colonoscopy

The underpinning rationales for the NETI training model are:

- Greater emphasis is needed on improved standards for education and training
- High quality training can only take place in units of overall high quality
- The needs of clinical service delivery must be balanced hand-in-hand with the needs of training
- Bowel cancer screening requires standards and accreditation for quality assurance of consultants and independent endoscopists
- Trainees require high quality and well-trained trainers.

NETI developed a range of courses targeted at different levels of experience. A high standard of training and practice for gastrointestinal endoscopy is promoted via a range of modalities:

- Lecture style presentations
- Use of video, simulators and other multi-media tools
- Improving the number of lists available to trainees
- Improving co-operation between specialities
- Ensuring trainees keep accurate log-books
- Interdisciplinary training and supervision across units, hospitals and States/Territories
- Increased access to training lists for trainees in a wider range of healthcare settings.

NETI training programs may become more formally linked to certification and, eventually, to re-certification as a result of facilities and practitioners sharing information on the clinical performance indicators for colonoscopy through electronic or other forms of documentation used to record and report on the procedure and outcomes.

NETI Curriculum and Competencies

The Clinical Skills Development Service – a branch of Queensland Health’s Centre for Healthcare Improvement (previously known as the Queensland Health Skills Development Centre) – developed the pre-clinical curriculum, “A Colonoscopy Competency Framework Derived from Task Analysis” [\(Appendix 4\)](#) as part of their brief to devise a “Development and Evaluation of a National Colonoscopy Training Program”.

The NETI curriculum [\(Appendix 5\)](#) has subsequently been referenced by the Royal Australasian College of Physicians (RACP), and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) has documented its support [\(Appendix 6\)](#). Members of the Royal Australasian College of Surgeons are attending the Colonoscopy Workshops, and have said they are supportive of the NETI courses. The General Surgeons Australia (GSA) has provided support through promulgation of the NETI Courses via their website.

iii. NETI Train-the-Colonoscopist-Trainer (TCT) Course

Levels

The TCT course is specifically designed for supervisors actively supervising trainees.

Format

This 2-day course was adapted for the Australian environment from the *United Kingdom Gloucester Royal Infirmary* Model developed by Dr. Roland Valori and Dr. John Anderson. This tested model, administered by the JAG and utilised by the United Kingdom NHS, is designed to take trainers out of their comfort zone to maximise the likelihood of long-lasting learning. It is intensive, challenging and highly interactive.

Content

- Objective setting
- Adult education theory applied to psychomotor skills teaching
- Skills teaching techniques
- Practical aspects of colonoscopy skills training
- Optimising the training environment
- Endoscopy training with registrars and patients
- Critique and critical reflection
- Assessment tools

A copy of the NETI TCT workshop faculty guide is attached ([Appendix 7](#)).

Key Benefits

- Targeted endoscopy room teaching skills
- Adult educational concepts equip delegates with the tools to become better trainers
- Critical reflection upon teaching skills and clinical practice
- Use of assessment, measurement and development tools in colonoscopy

Access

NETI aimed to have at least one TCT trained supervisor in each major teaching hospital. To date, NETI have achieved this target in all areas except Darwin and Tasmania. Initial recruitment for the first cohort was achieved by targeted selection. Recruitment for subsequent courses was achieved by targeting key teaching hospitals, self-selection and achieving a balance of delegates from rural and metropolitan centres.

Fig 2: Attendees of a NSW TCT Course with Trainers from JAG, UK (2009)

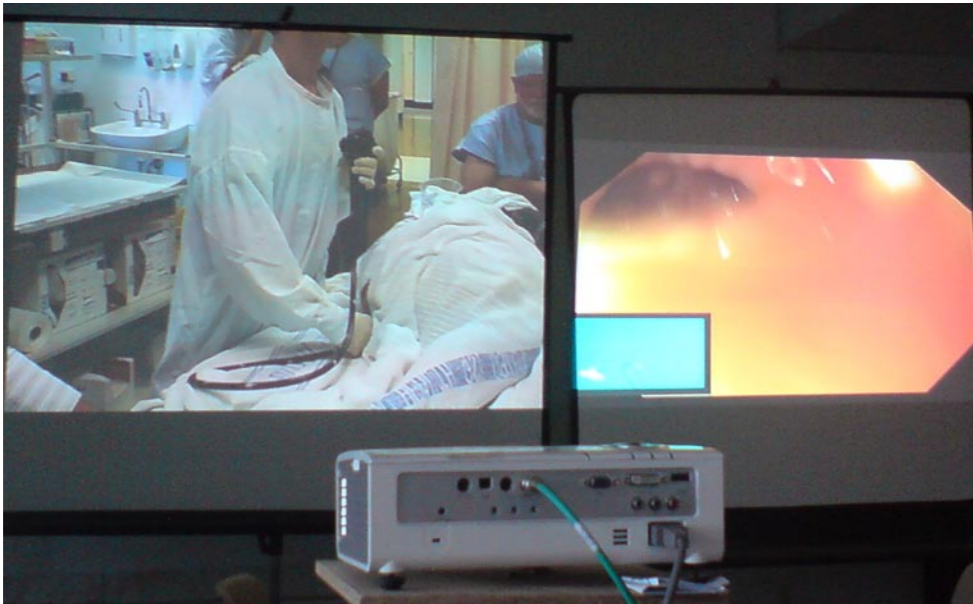


Back row: Arthur Grillas, Doug Routley, Tony Donaghy, John Anderson, Roland Valori, Mark Schoeman, Justin Evans, Caroline Wright. Front row: Cameron Bell, Andrew Taylor, Mark Appleyard, Sean Griffin.

Fig 3: TCT Workshop (Day 2) at Royal North Shore Hospital, NSW (2009)



Fig 4: Live Colonoscopy Demonstration during TCT Course



Supervisors who have Completed the TCT Course

State/ Territory	NSW/ACT	QLD	SA/NT	VIC / TAS	WA	TOTAL
Number	12	11	14	18	7	62

Year	Name	State
2008	Dr Robert Chen	VIC
2008	Dr Finlay Macrae	VIC
2008	Dr David Rubenstein	VIC
2008	Dr Andrew Taylor	VIC
2008	Dr Michael Bourke	NSW
2008	Dr Peter Prichard	VIC
2008	Dr Cameron Bell	NSW
2008	Dr Rupert Leong	NSW
2008	Dr David Williams	NSW
2008	Dr Mark Schoeman	SA

Year	Name	State
2008	Dr Philip Craig	NSW
2008	Dr Philip Douglas	SA
2008	Mr Matt Rickard	NSW
2008	Dr David Hewett	QLD
2008	Dr Robert Franz	QLD
2008	Mr Andrew Luck	SA
2008	Dr Bradley Kendall	QLD
2008	Dr Enrico Roche	QLD
2008	Dr Kevin Tang	QLD
2008	Dr Gregor Brown	VIC

Year	Name	State
2009	Dr Caroline Wright	NSW
2009	Dr Arthur Grillas	NSW
2009	Dr Sean Griffin	NSW
2009	Dr Justin Evans	NSW
2009	Dr Doug Routley	NSW
2009	Dr Anthony Donaghy	NSW
2009	Mr James Moore	SA
2009	Dr William Tam	SA
2009	Dr Nam Nguyen	SA
2009	Dr Peter Bampton	SA
2009	Dr Edward Teo	SA
2009	Dr David Rodda	SA
2010	Dr John Edwards	QLD
2010	Dr Luke Hourigan	QLD
2010	Dr John Masson	QLD
2010	Dr Ruth Hodgson	QLD
2010	Dr Gillian Mahy	QLD
2010	Dr Andrew Bryant	QLD
2010	Dr Rhys Vaughan	VIC
2010	Dr Bill Connell	VIC
2010	Dr Ashley Miller	VIC

Year	Name	State
2010	Dr Donald Ormonde	WA
2010	Dr Sina Alexander	VIC
2010	Dr Peter De Cruz	VIC
2010	Dr Richard Holloway	SA
2010	Mr Ian Faragher	VIC
2010	Dr. Richard Johnson	SA
2010	Miss Michelle Thomas	SA
2010	Miss Elizabeth Murphy	SA
2010	Dr. Paul Hollington	SA
2011	Dr Sally Bell	VIC
2011	Dr Geoff Hebbard	VIC
2011	Mr Michael Johnston	VIC
2011	Dr John Iser	VIC
2011	Mr John Stuchbery	VIC
2011	Dr Barry Morphet	VIC
2011	Miss Marina Wallace	WA
2011	Dr Hooi Ee	WA
2011	Dr Dev Segarajasingam	WA
2011	Dr Nick Kontorinis	WA
2011	Dr Matt Zimmerman	WA
2011	Dr Callum Pearce	WA

Evaluation

Despite the confronting nature of the workshop, the overwhelmingly positive response from delegates, along with anecdotal feedback from trainees, indicates that this method is achieving its goals (Appendix 8). Whilst current funding did not allow a detailed skills audit and impact assessment, NETI is currently in discussion with JAG to ascertain the suitability of the JAG Endoscopy Training System (JETS) follow-up and evaluation model.

The success of the self-funding model will determine the continued course uptake by delegates and the ongoing evaluation process.

iv. NETI Endoscopy Learning Centre

Levels

The endoscopy learning centre is specifically designed for:

- The exposure of new trainees to a variety of quality supervisors from across the country
- Existing colonoscopists to update skills.

Format

This is an endoscopy simulation centre staffed by leading colonoscopist trainers. The learning program is conducted annually over a four-day period during the gastroenterology annual meeting, Australian Gastroenterology Week (AGW).

Content

- Practical colonoscopy exercises

Key Benefits

- Interactive exercises with simulators
- Acquisition of the basic skills to perform safe, accurate total colonoscopy
- Interdisciplinary training and supervision from a range of colonoscopist trainers from across Australia.

Fig 5: The NETI Endoscopy Learning Centre at AGW (2009)



Fig 6: Two of the Simulators Inside the NETI Endoscopy Learning Centre at AGW (2010)



Access

Open access to all trainees and attendees at AGW.

NETI Colonoscopy Learning Centres

Date	Location
2007	Perth
2008	Brisbane
2009	Sydney
2010	Gold Coast
2011	Brisbane

Evaluation

The NETI Colonoscopy Learning Centres are an extremely important component of the colonoscopy learning program. Trainees benefit from the opportunity to meet and learn from a range of specialists who have undertaken the TCT course. Rather than relying on an individual consultant’s practice, in this environment trained supervisors reinforce best-practice techniques and accepted quality standards. Additional support and counsel can be directly sought by the trainee.

In 2009, the GESAI Endoscopy Learning Centre was attended by a representative from Medicare. They were available to reinforce aspects of the program, especially the completion of the required paperwork, and to answer delegates’ questions.

This is a busy event for the trained supervisors, who often have a range of other obligations to committees and their own trainees. As the Endoscopy Learning Centre is labour intensive, the development of voluntary staff rosters across all TCT trained supervisors is necessary and has been achieved.

v. NETI Introductory, Basic and Advanced Courses and Workshops

GutSchool / The NETI Introductory Workshop

NETI Introductory workshops have been developed into a program for new trainees called *GutSchool*.

Levels

This course was specifically designed for new trainees in gastroenterology (RACP and RACS). Current registered gastroenterology trainees and those offered a gastroenterology placement in the following year are invited to attend.

Format

The Introductory workshop was initially designed as a learning program conducted over one day, supported by lectures, vignettes and the use of simulators. Over time it has evolved into an annual two day event designed specifically for trainees to attend prior to commencing advanced training in gastroenterology. As well as the introductory modules, trainees are encouraged to network and work with peers and supervisors from around Australia.

Content

- History of endoscopy
- Basic anatomy
- Quality and indications for colonoscopy
- Colonoscope design, function, and accessories
- Insertion
- Steering
- Withdrawal
- Infection control
- Assessment, consent and communication
- Pathology and report writing

A copy of the *GutSchool* / NETI Introductory Course handbook is attached (Appendix 9).

Key Benefits

- Understanding of the basic principles and practice of colonoscopy and the equipment used
- Understanding the provision of a colonoscopy service and the resources needed.

Fig 7: New Trainees Working with Simulators at GutSchool (2010)



Access

The *GutSchool* / NETI Introductory Course is run across Australia. This is a supported activity. A travel and accommodation assistance grant program is available to registered trainees in gastroenterology residing in remote locations within Australia and its external territories.

Courses to Date

Date	Location	Attendees	Additional Notes	Faculty
2008	Brisbane	6	New trainees and one surgeon overseas trained, no endoscopy training	Dr David Hewett Dr James Daveson
November 2010	Lancemore Hill, Melbourne	37	33 new trainees, and held in conjunction with the inaugural <i>GutSchool</i>	A/Prof Ian Norton Dr Gregor Brown Dr David Hewett Prof Michael Grimm Dr Richard La Nauze Ms Bronwyn Harris
November 2011	Brisbane			

Trainee Evaluation

Evaluations of the *GutSchool* by attendees indicate that this method is achieving its stated goals.

The NETI Basic Colonoscopy Course

Levels

This course was specifically designed for physician and surgeon colonoscopists and trainees to cover the basic principles and practice of colonoscopy.

In addition, the nature of this course reinforces key learnings for advanced registrars (who may assist with live colonoscopy cases) and trained supervisors (who utilise their TCT skills).

Format

Conducted over one day, the learning program includes basic colonoscopy techniques, expert panel discussion on clinical challenges and state-of-the-art lectures by faculty. This is interspersed with live-streamed colonoscopy demonstrations of consenting patients performed at centres of excellence.

Content

- Preparation for Colonoscopy
 - Indications
 - Risks
 - Bowel preparation
 - Informed Consent
- Colonoscope equipment, accessories and handling
- Principles and methods of colonoscope insertion, including techniques in difficult to intubate patients
- Principles and methods of colonoscope withdrawal
- Sedation and patient monitoring during colonoscopy
- Anticoagulation and use of antibiotics
- Diathermy theory, methods and safety
- Infection control and endoscope reprocessing[#]
- Polypectomy
- Quality use of pathology
- Colorectal surgery – The basics
- Quality indicators and report writing

[#] Where available, GI nurses have been invited to present the Infection Control segment and this has become accepted practice in several units.

A copy of the NETI Basic Colonoscopy Course Workshop Program and Syllabus is attached [\(Appendix 10\)](#), together with a snapshot video of one of the lectures.

Key Benefits

- Understanding of the basic principles and practice of colonoscopy and the latest equipment used
- Acquisition of the basic skills to perform safe, accurate total colonoscopy
- Understanding the provision of a colonoscopy service and the resources needed.

Fig 8: Attendees at a NETI Basic Colonoscopy Course, South Australia (2011)



Fig 9: Technician Setting up Cameras in the Endoscopy Suite for Live Colonoscopy Demonstrations for Students Attending a NETI Basic Colonoscopy Course



Access

The NETI Basic Colonoscopy Course is run across Australia. This is a supported activity. A travel and accommodation assistance grant program is available to registered trainees in gastroenterology who reside in remote locations within Australia and its external territories.

Courses to Date

Date	Location	Attendees	Faculty Lead
2008	Adelaide	30	Dr. Mark Schoeman
2008	Brisbane	110	Dr. David Hewett
2009	Melbourne	35	Dr. Peter Tagkalidis
2009	Melbourne	26	Dr. Gregor Brown
2010	Sydney	22	A/Prof. Ian Norton
2010	Melbourne	26	Dr. Gregor Brown
2011	Adelaide	24	Dr. William Tam
2011	Melbourne	20	Dr. Gregor Brown
2011	Sydney	Planned	A/Prof. Ian Norton
2012	Brisbane	Planned	Dr. Mark Appleyard

Statistics

Over 250 physicians and surgeons have attended the workshops, as well as a number of unit staff who have been able to attend one or two of the presentations and live case demonstrations as part of their normal duties on the day.

Evaluation

Evaluations of the workshop by attendees indicate this course is achieving its stated goals (Appendix 11).

Additional Resources

A review of the delegates feedback indicated that the provision of additional resources were required.

A course information package was created. In addition to the NETI Basic Colonoscopy Course Workshop Program and Syllabus (Appendix 10), the package also contains:

- The Endoscopy Handbook (Appendix 12). This is designed for new Trainees in Gastroenterology and is in a loose leaf format to enable updating. It is planned that this document will eventually be part of the eLearning package.
- An Endoscopy DVD supplied by Olympus

- The GESA “Infection Control in Endoscopy Guidelines” (Appendix 13)
- The GESA “Early Detection, Screening and Surveillance for Bowel Cancer” (Appendix 14)
- Consumer leaflets with information on Bowel Polyps and Colonoscopy (Appendix 15)

The need for information for patients on bowel preparation was highlighted, and this is currently being addressed by GESA.

The NETI Advanced Course

The NETI Advanced Course has not yet been established. Initial concerns were raised over cost effectiveness and the level of skills training required to undertake major polypectomies, and attendant liability risks.

These concerns have now been satisfied, and NETI plan to develop an advanced course as soon as appropriate faculty and facilities become available.

vi. Training Equipment – Including Scope Guide

NETI verified and procured the latest technologies for training Australian colonoscopists.

The Wolfson Unit for Endoscopy, St Marks London, UK has been recognised as a world centre of excellence by the World Organization for Digestive Endoscopy (WODE). This unit developed the product, known as Scope Guide™ – UPD, and has set precedence to use Scope Guide™ as a preferred training aid for colonoscopy.

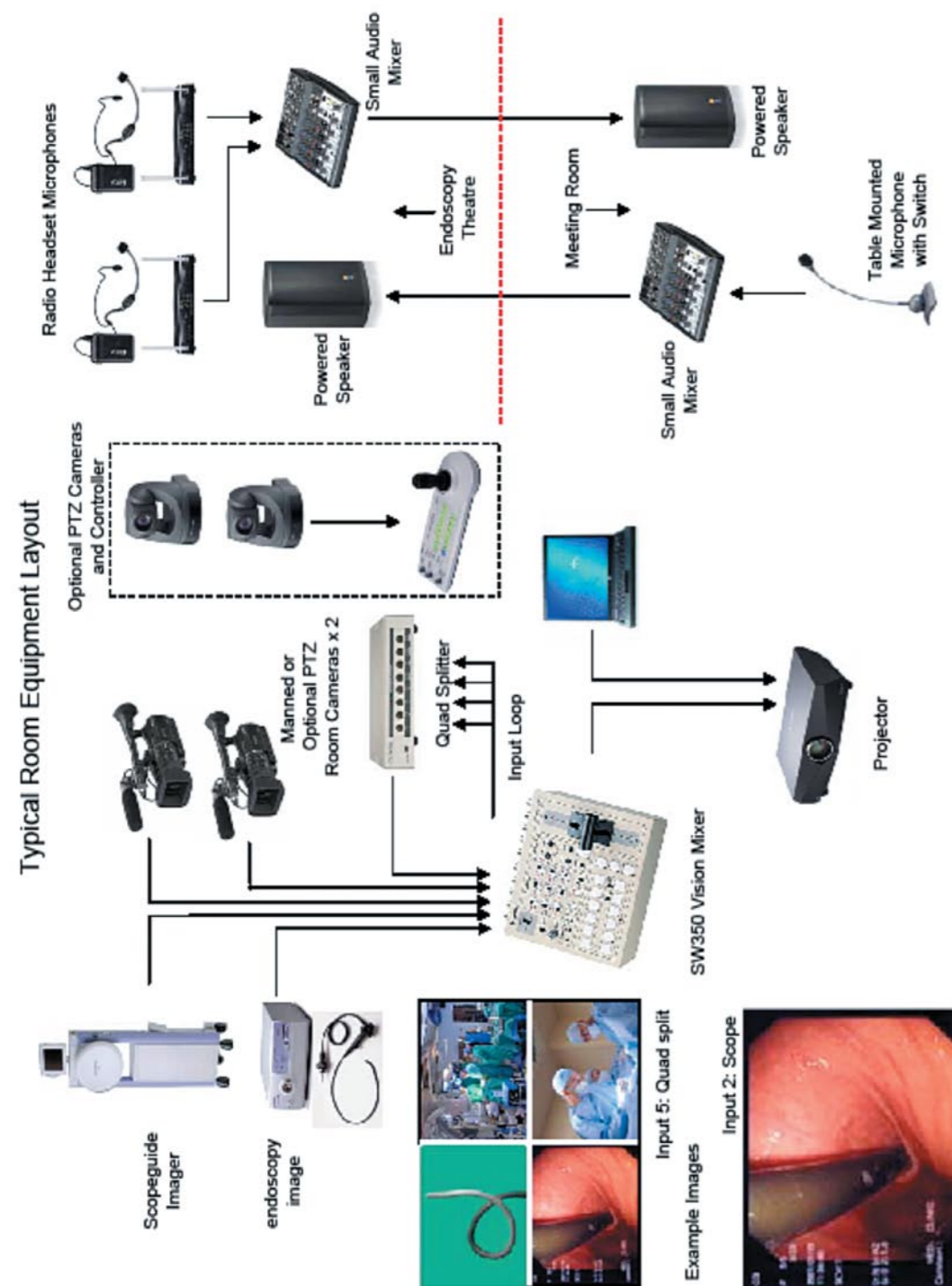
Scope Guide™ is an adjunct to colonoscopy where the position of magnetic guides incorporated into the length of the colonoscope are detected and displayed on a separate screen. This gives an approximate guide to the progress of the procedure and also the presence of loops.

NETI supplies, delivers and sets up all equipment when each NETI training course is conducted.

In between scheduled NETI courses, the purchased equipment is loaned to hospitals across the country to run specialised training in individual endoscopy units. To qualify, the hospital must have proceduralists on staff who have completed the Train-the-Colonoscopists-Trainer (TCT) course. This allows supervisors to continue using the Scope Guide and UPD scopes in road cases, where it is not available, in their own clinical environment. This has had wide uptake across the country.

Servicing and maintenance agreements have been set up to maintain the equipment for the next three years.

Fig 10: The Training Equipment Purchased by GESA for NETI



B. QUALITY ASSURANCE IN COLONOSCOPY

All stakeholders recognise the need in Australia for colonoscopy to be performed with the highest possible quality, particularly in the era of colon cancer screening with the NBCSP, since the success (and cost-effectiveness) of the program requires that patients referred because of a positive FOBT receive a colonoscopy that will *accurately* detect or exclude neoplasia as the cause of the positive initial screening test. GESA, together with other key stakeholders including the Colorectal Surgical Society of Australia and New Zealand (CSSANZ) and the General Surgeons Australia (GSA), have developed a framework for appraisal, certification and recertification that sets out the competencies and standards for validation based on good medical practice. This framework provides guidance for measures of competence, ongoing specialist standards and supporting information that is required to demonstrate and assess high professional standards for endoscopy.

i. The Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (CCRTGE)

CCRTGE / Conjoint Committee

The Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE or 'Conjoint Committee') is the national body formed to assess training in endoscopy.

The role of the Conjoint Committee is to set the minimum standards for training in gastrointestinal endoscopy that will permit unsupervised practice of the procedures. Procedures currently assessed by the committee are gastroscopy (adult and paediatric), colonoscopy (adult and paediatric), endoscopic retrograde cholangiopancreatography (ERCP) and Endoscopic ultrasound (EUS).

Applicants are expected to demonstrate cognitive and interpretative skills combined with a clear understanding of the role of endoscopy in patient management. These skills are considered by the committee to be as important as technical skills acquired during training.

Adequate facilities for training in endoscopy should be available in major hospitals. Trainees are expected to keep a prospective log book of their endoscopy experience. Logged cases must be signed off by a supervisor who attests to the veracity of the logbook. Trainees are encouraged to attend relevant workshops during their endoscopy training (see section A for workshops and courses set up by NETI). Successful applicants are encouraged to maintain continuing medical education in the field of endoscopic practice, including regular audits of their own endoscopic practice.

Furthermore, as part of their training, the committee expects applicants to:

- Have received training in radiological and pathological findings as well as the technical aspects of endoscopy
- Have received training in sedation practices pertaining to endoscopic procedures based on the current document, **Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures – Review PS9 (2010)**

- Demonstrate an understanding of the principles and practice of cleaning and disinfection of modern endoscopic instruments as outlined in the current edition of ***Infection Control in Endoscopy***
- Keep abreast of current endoscopic literature.

CCRTGE Structure and Governance

The success and strength of the CCRTGE is based on broad representation and support from stakeholders, with equal representation from GESA, the Royal Australasian College of Physicians (RACP) and the Royal Australasian College of Surgeons (RACS). GESA, RACP and RACS are the parent bodies. The committee is made up of four physicians and four surgeons, supported by an Administrative Secretariat that resides in GESA.

Fig 11: Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) as at 30/4/2011

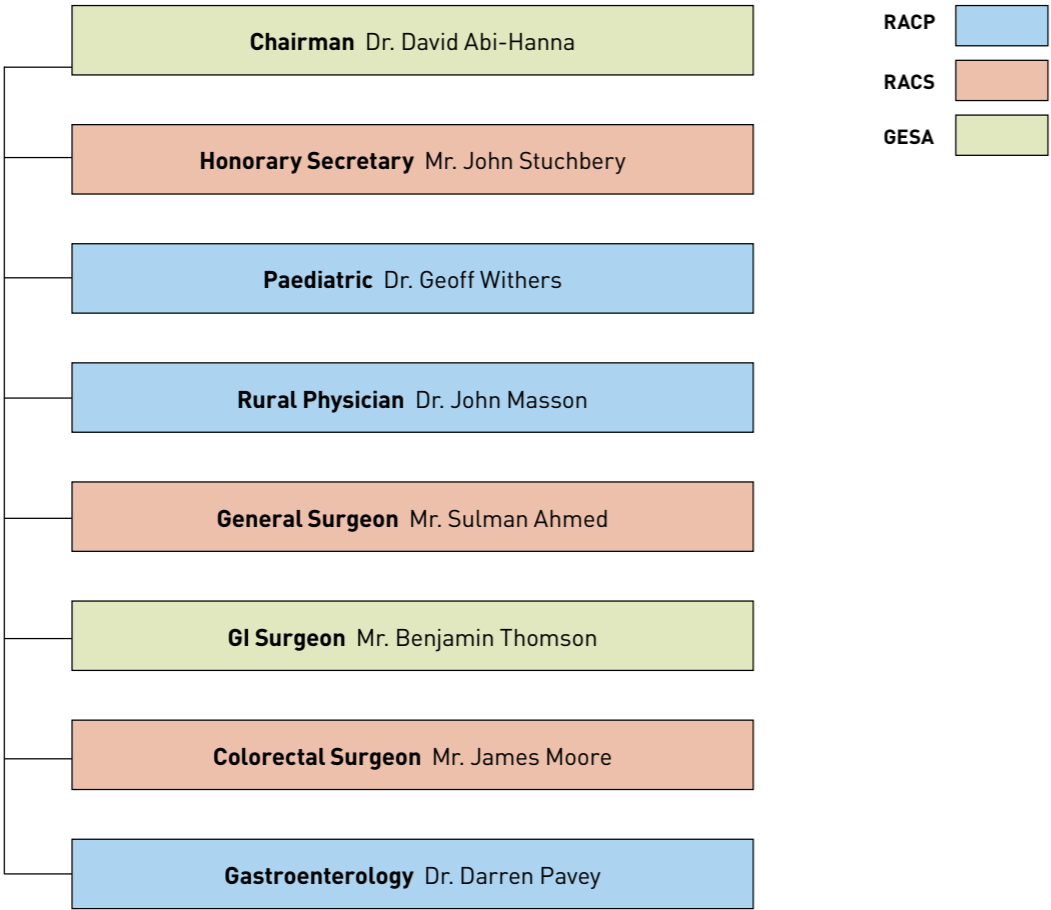
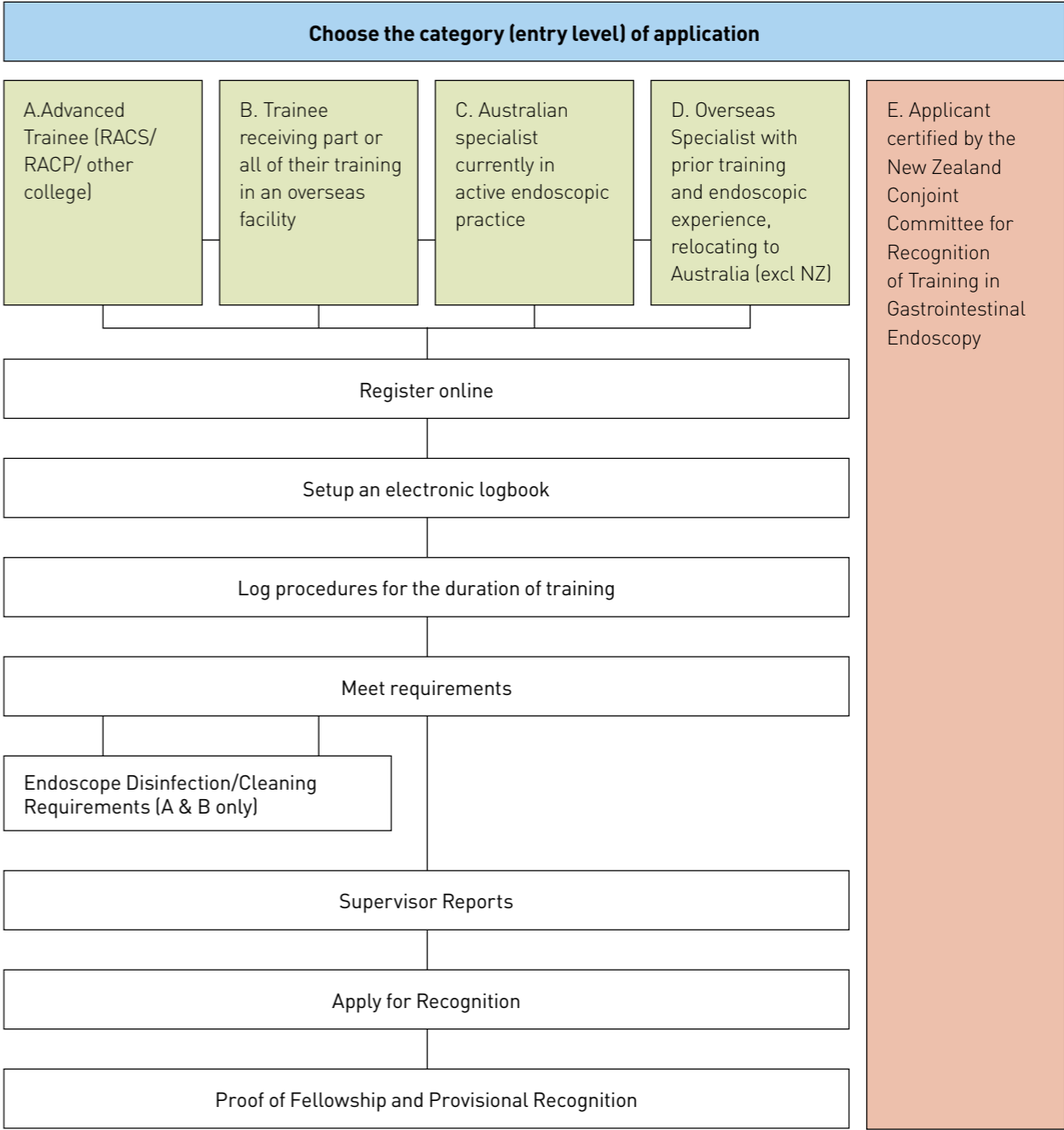


Fig 12: The Pathway for Certification for Colonoscopists



ii. Certification for Colonoscopy

The purpose of trainee certification (previously known as Recognition of Training) is to assess the trainee’s competence at performing an endoscopic procedure and recognise their ability to perform the procedure independently. Whilst initial certification is not compulsory, many Australian hospitals, Area Health Services and day surgeries now require this certification as a prerequisite to credentialling practitioners to perform colonoscopy in their facility. This has resulted in Australia potentially having some of the most rigorous training standards in the world.

CCRTGE Outcomes

The trainee certification process has undergone a thorough review by the CCRTGE parent body. The CCRTGE will continue to review and develop the trainee certification process in line with evidenced-based, best practice quality indicators.

OBJECTIVE	OUTCOME	LEAD
CERTIFICATION		
Improve upon the existing certification system for proceduralists performing colonoscopy and ensure that the certification system is self-funding, and has the support of all key stakeholders.	Review of recognition of training, assessment of (and transition to) certification and certification criteria.	CCRTGE Committee Mr Andrew Luck
Stakeholders are comprised of: physicians and surgeons, (including registrars in training) who currently meet the eligibility criteria for recognition of training by the Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy.	New online log book system has replaced paper based logbook (See part C). Supported by all key stakeholders via their representation on the tripartite committee.	

Certification Criteria

The eligibility criteria reflect the trainee’s ability to practise.

Colonoscopy

Successful achievement of certification in colonoscopy involves assessment of trainee performance via their supervisor, along with assessment of specific skills such as caecal intubation in intact colons and independent, but supervised, performance of polypectomy.

CRITERIA	THRESHOLD
Unassisted, supervised, complete colonoscopies to the caecum and preferably to the ileum in patients with intact colons (i.e. with no prior colonic resection)	>100
Successful snare polypectomies	>30 patients
Caecal intubation rates on an intention-to-intubate basis*	>90%
Data certified	Endoscopic supervisor

** Procedures on patients with obstructing cancer or other condition resulting in non completion to caecum (e.g. severe colitis) must be recorded but are excluded from the calculation of overall intubation rate.*

Paediatric Colonoscopy

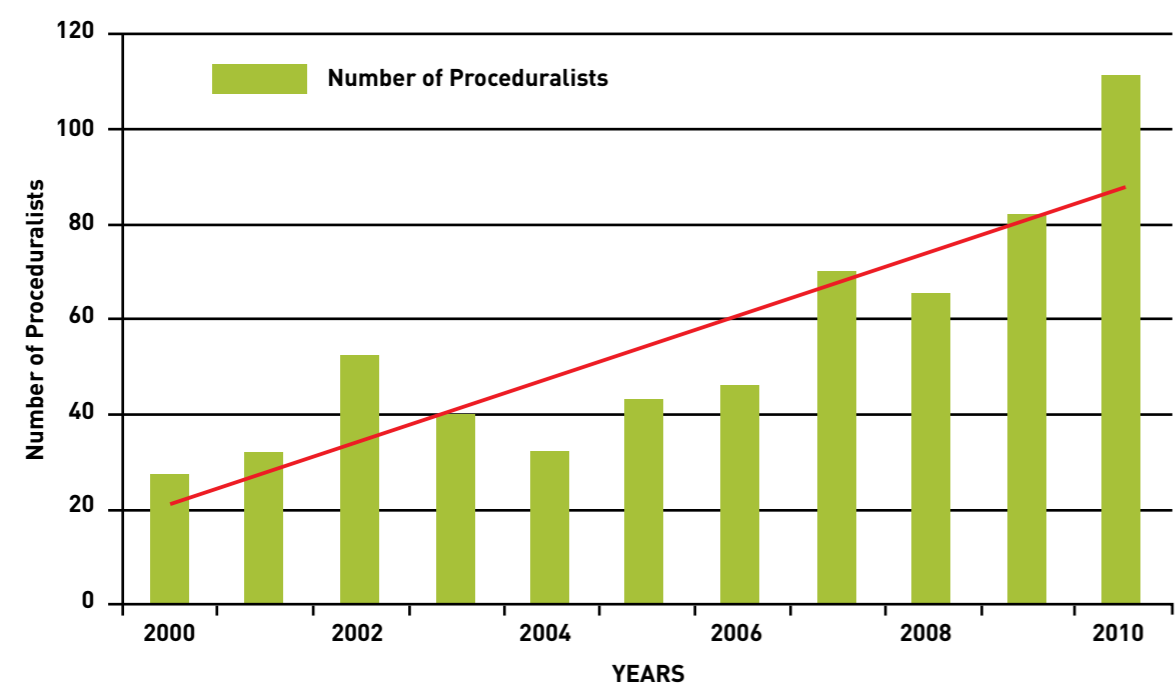
CCRTGE recommends that colonoscopy procedures in children thirteen years of age and under should only be performed by those who have satisfied the training requirements for paediatric endoscopy.

CRITERIA	THRESHOLD
Unassisted, supervised, complete colonoscopies to the caecum and preferably to the ileum in patients with intact colons (i.e. with no prior colonic resection)	>100
Procedures in paediatric patients under the supervision of a recognised paediatric colonoscopy supervisor	>75
Caecal intubation rates on an intention-to-intubate basis*	>90%
Polypectomy experience	Expected
Data certified	Endoscopic supervisor

** Procedures on patients with obstruction or other condition resulting in non completion to caecum (e.g. severe colitis) must be recorded but are excluded from the calculation of overall intubation rate.*

The threshold requirements listed above are considered to be the **absolute minimum** a trainee must achieve before consideration of an application for certification. The CCRTGE expects most applicants to significantly exceed these numbers during training in order to be considered competent. Competence is assessed according to specific quality measures and not merely by the completion of minimum procedure numbers.

Fig 13: Numbers of Proceduralists Certified in Colonoscopy from 2000



There are currently a few Supervisors who are still not CCRTGE recognised. All stakeholders are working to encourage the membership of the parent bodies to apply. The Grandfather clause has been reintroduced and the avenue to apply for recognition is available.

iii. Recertification

The maintenance of professional standards (MoPS) fosters continuing scholarship in order to maintain a high standard of clinical practice. The principal role is educational and should validate continuous medical education (CME), quality assurance (QA), and other self-improvement educational activities.

The recertification process demonstrates that certified proceduralists aim to confirm that they meet quality endoscopy standards at intervals of no longer than three years.

GESA Outcomes

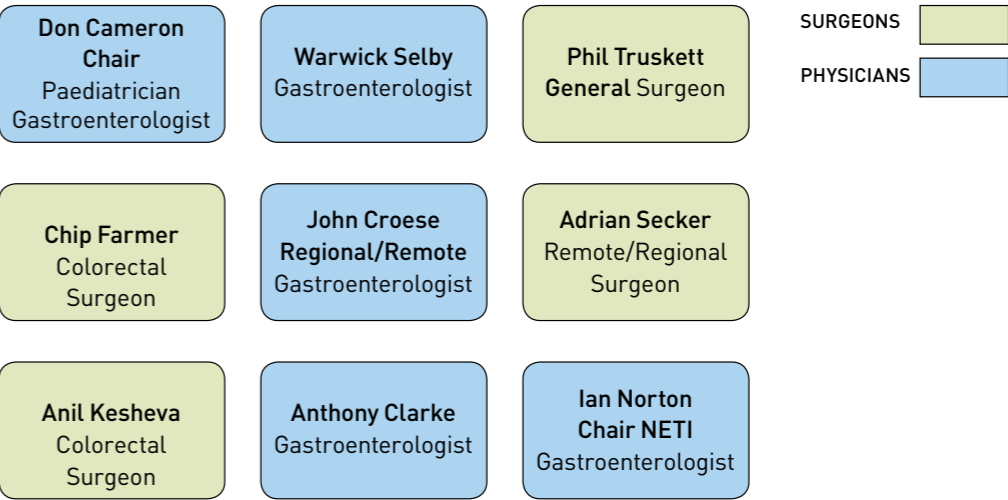
GESA established a recertification committee to develop and implement the recertification process.

OBJECTIVE	OUTCOME	LEAD
RECERTIFICATION		
Establish and define the role of an overarching committee for re-certification of proceduralists performing colonoscopy which has the support of all key stakeholders.	Establishment of the Conjoint committee for recertification in colonoscopy (CCRC)	GESA A/Prof. Ian Norton A/Prof. Don Cameron

Conjoint Committee for Recertification in Colonoscopy (CCRC)

A separate committee dedicated to recertification, the Conjoint Committee for Recertification in Colonoscopy (CCRC), was established in 2009.

Fig 14: Conjoint Committee for Re-certification in Colonoscopy (CCRC) (Steering Committee as at 30/12/2010)



Members of the CCRC include representatives from the parent bodies involved in CCRTGE: Gastroenterological Society of Australia (GESA), the Royal Australasian College of Surgeons (RACS), the Royal Australasian College of Physicians (RACP), and the Colorectal Surgical Society of Australia and New Zealand (CSSANZ).

The responsibilities for CCRC are to:

- Develop the criteria for recertification
- Assess applications for recertification and those chosen for audit
- Develop criteria for outliers
- Monitor the recertification process and make recommendations on behalf of the parent bodies
- Set up an appeals mechanism
- Run a pilot program prior to implementation.

The committee is administered by GESA.

CCRC Outcomes

The CCRC committee has developed a voluntary, self-funding revalidation process in line with evidenced-based, best practice quality indicators.

OBJECTIVE	OUTCOME	LEAD
RECERTIFICATION		
Develop a self-funding recertification system for proceduralists performing colonoscopy which has the support of all key stakeholders.	In process Budget developed Other stakeholders consulted	Prof. Michael Grimm
Commence implementation of re-certification of proceduralists performing colonoscopy across Australia.	Expected to commence in pilot form (voluntary participation) in 2012	CCRC A/Prof. Don Cameron

Recertification Criteria for Continued Practice

The quality criteria for recertification that are about to be trialled are:

CRITERIA	THRESHOLD
Existing certification with the CCRTGE	
Colonoscopies in previous 3 years	>150
Adenoma detection rate in 100 consecutive procedures	>10%
Polyp retrieval rate	>90%
Caecal intubation in 100 consecutive procedures	>90%
Lifetime perforation rate (complication rate)	To be confirmed

By maintaining a logbook proceduralists are able to demonstrate that they continue to meet quality endoscopy standards.

Recertification Pilot Model

Voluntary Model

The scheme is voluntary. The membership will be encouraged to participate. As the program becomes established, interest groups such as the ACHS, state licensing bodies, private insurance companies, individual institutions and indemnity providers may wish to utilise this re-certification system at their own discretion – as has gradually become the case with initial certification.

Three-year Cycle

On a three-year rotation basis, each practitioner is required to submit an electronic logbook of 150 consecutive procedures demonstrating the quality criteria for recertification. The practitioner should also submit a tally of colonoscopy numbers over that three-year period.

Fig 15: The Recertification Electronic Logbook

Create New

Show10entries

Search:

Log Id	Date Of Procedure	Patient Age	Patient Gender	Sedation	Intact Colon	Scope Passed To Caecum	Completed Unassisted	Reason For Non Completion	Withdrawl Time	Total Procedure Time	Polypectomy Performed	Complications	Sample Retrieved	Pathology Result	
Edit	24	01/06/2011	100	Female	Proceduralist	True	True	True	N/A	33	31:22:23	<input type="checkbox"/>	None	<input checked="" type="checkbox"/>	er
Edit	11	31/05/2011	12	Male	Anaesthetist	False	False	True	N/A	1	2	<input checked="" type="checkbox"/>	None	<input type="checkbox"/>	11111111111111111111222222255555555
Edit	9	20/05/2011	13	Male	Anaesthetist	True	True	Not Set	N/A	1	2	<input checked="" type="checkbox"/>	None	<input type="checkbox"/>	4
Edit	14	09/05/2011	56	Female	Anaesthetist	True	True	Not Set	N/A	4	47	<input checked="" type="checkbox"/>	None	<input type="checkbox"/>	er
Edit	13	08/05/2011	34	Female	Anaesthetist	True	True	Not Set	N/A	4	44	<input checked="" type="checkbox"/>	None	<input checked="" type="checkbox"/>	23
Edit	8	04/05/2011	13	Male	Proceduralist	False	True	False	N/A	2	3	<input checked="" type="checkbox"/>	Other	<input checked="" type="checkbox"/>	d
Edit	12	02/05/2011	23	Female	Anaesthetist	True	True	Not Set	N/A	2	22	<input checked="" type="checkbox"/>	None	<input type="checkbox"/>	23
Edit	10	01/01/2011	21	Male	Proceduralist	True	True	True	Colon not intact	4	34	<input type="checkbox"/>	None	<input checked="" type="checkbox"/>	n

Showing 1 to 8 of 8 entries

[Back to Certifications Dashboard](#)

First Previous 1 Next Last

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Funding

The Department of Health and Ageing has supported the program infrastructure, (database) development, consultations and trials. The program will be then self- funded upon implementation.

Audit Process

An auditing system will also be introduced with 5% of those submitting for re-certification being chosen at random for audit.

Failure to Meet the Criteria

GESA will provide assistance for proceduralists who wish to maintain their colonoscopy skills and competencies or gain updated clinical and diagnostic skills, by way of workshops and, where possible and needed, remedial training.

C. IMPROVED DATA COLLECTION, STANDARDISED ASSESSMENT AND APPRAISAL

In order to streamline the logbook data collection as well as the assessment and review process, GESA began the conversion from paper-based to online logbooks.

The main aim was to create a paperless and standardised procedure archive to more truly reflect current practices. Ease of audit was also a consideration.

Fig 16: Logbook and Paperwork Received from one Registrant for CCRTGE



- This was a major shift of focus for Supervisors. The old paper-based system:
- Required Supervisors to sign off on manual hard copy log books (often done some time after the procedure had been completed)
 - Left trainees with several pages of books from different training locations and different Supervisors
 - Necessitated the CCRTGE members and administrative staff to spend many hours sorting out pages, retuning incomplete applications and checking percentages.

In 2008, a new electronic system was designed, piloted and released Australia-wide under the management of the CCRTGE. This was supported in part by DoHA funding to improve the data collection system for the applicants.

Trainees are now able to register for certification using the new electronic logbook on an upgraded website.

A direct link has been created which now takes the trainee to a certification page. This page lists the criteria for certification, eligibility criteria and provides a means to electronically maintain logbooks of procedures both attempted and completed.

While the initial rollout of the online logbook was met with some resistance, with minor modifications it has become an effective system which is now widely accepted. Paper logbooks continue to be phased out. Only proceduralists who have started with the paper-based system can continue with its use.

The advantages of online logbooks and data collection compared with the paper-based system are:

- Logbooks are completed closer to the time of the actual procedure
- Trainees are required to communicate with their supervisors regularly (after every 50 procedures) to ensure their logbooks are signed off
- On-time applications cannot be processed after the closing date
- Applications cannot be submitted unless the Supervisor's report is completed
- Correct data – all calculations are inbuilt into the system
- All requirements (albeit the minimum) need to be met before logbooks can be submitted for review
- Supervisor's reports are now a focus of any discussion at the CCRTGE meetings
- Time of meetings and associated costs are reduced
- All applications for recognition of training can now be sent electronically to the Committee, saving money and creating a paperless environment.

A sample copy of the new electronic interface is available below.

Fig 17: Sample of the Certification Log book Entry

CCRTGE Recognition Management and Database

Applications Closings 129 days 02:53:51

Logbook

Switchboard > View Logbook Entries

Colonoscopy Logbook - Mr Andrew Mitcham

Change Results Per Page 10

Back to Switchboard

Edit	Date	Patient Age	Patient Gender	Sedation	Intact Colon	Scope passed to caecum/ileum?	Completed Unassisted	Reason For Non Completion	Withdrawal Time (mins)	Total Procedure Time (mins)	Polypectomy Performed	Complications	Supervisor's Acknowledgment
View													
Delete	2/12/11	32	M	Proceduralist	✓	✓	✓	N/A	34	56	○	None	✓ Professor Tee Oa
Delete	1/12/11	34	M	Proceduralist	✓	✓	✓	N/A	32	37	○	None	✓ Professor Tee Oa
Delete	1/12/11	45	M	Proceduralist	✓	✓	✓	N/A	21	34	○	None	✓ Professor Tee Oa
Delete	2/08/10	21	M	Proceduralist	✓	✓	✓	N/A	21	55	○	None	✓ Professor Tee Oa
Delete	15/05/09	21	F	Proceduralist	✓	✓	✓	N/A	21	43	○	None	✓ Professor Tee Oa

Change Results Per Page 10

Fig 18: Sample of Logbook Summary Sheet

CCRTGE Recognition Management and DatabaseApplications Closings 129 days 02:54:09

Summary Sheet

Subsubject > Procedure Summary Sheet

Colonoscopy Summary Sheet - Mr Andrew Mitcham

PROCEDURE REQUIREMENTS	REQUIREMENTS MET?	SUPERVISOR REQUIREMENTS	SUPERVISOR REQUIREMENTS MET?
Minimum of 120 unsolicited procedures	5 procedures	Supervisor report(s) submitted	
Minimum of 33 more polypectomies	5 more polypectomies	Cleaning procedures acknowledged	
90% success rate in last 50 procedures with intact colons	100% success rate	Adm to apply	

SUMMARY OF ALL PROCEDURES PERFORMED (GROUPED IN LOTS OF 25):

Date From	Date To	Total Attempted	Intact Colons	Total Cancer Or Colitis	Total Completed Unsolicited	% Success	Mean Time (mins)	Complications	No with Severe Polypectomies
15 May 2009	2 Jan 2010	5	5	0	5	100%	45	0	1

SUMMARY OF LAST 50 PROCEDURES PERFORMED:

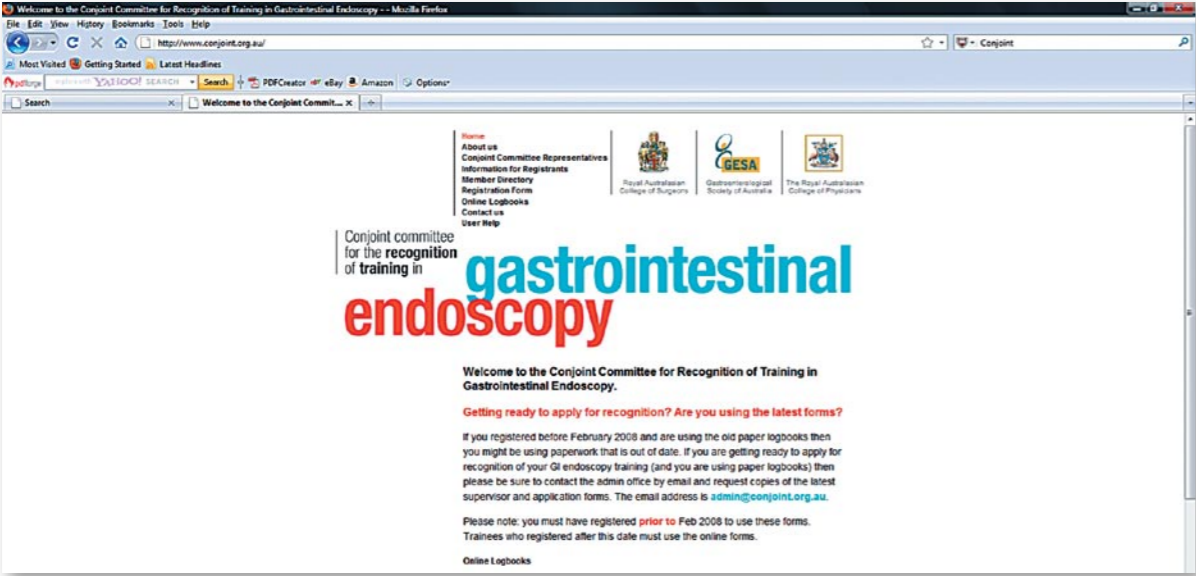
Date From	Date To	Total Attempted	Intact Colons	Total Cancer Or Colitis	Total Completed Unsolicited	% Success	Mean Time (mins)	Complications	No with Severe Polypectomies
15 May 2009	2 Jan 2010	5	5	0	5	100%	45	0	1

OVERALL SUMMARY OF ALL PROCEDURES PERFORMED:

Date From	Date To	Total Attempted	Intact Colons	Total Cancer Or Colitis	Total Completed Unsolicited	% Success	Mean Time (mins)	Complications	No with Severe Polypectomies
15 May 2009	2 Jan 2010	5	5	0	5	100%	45	0	1

Back to Switchboard

Sample sheet includes clinical indications: a) screening b) surveillance c) indicative symptoms



A new tab has been created which will take the trainee to a certification page. This lists the criteria for certification, eligibility criteria and provides a means to electronically maintain logbooks of procedures both attempted and completed.

An online system has also been established for the recertification program.

3. BUDGET

A Financial statement and audited report is attached as Appendix 16.

4. MODEL FOR THE FUTURE

The Council of GESA have affirmed that the NETI Endoscopy Training Plan is a core business of the Society. A major component of NETI’s work is to assure the quality of initial training in colonoscopy in Australia, and the maintenance of those standards throughout a professional’s career. NETI/GESA will build on the work that the Commonwealth has supported via the Project in a number of ways:

Web-Based Recording of Learning in Colonoscopy

The Project has allowed the development of a web-based vehicle for:

- (i) Recording and documenting the experience of trainees, and
- (ii) The verification of the data entered by the trainee’s supervisor.

This, when fully implemented, will substantially improve the documentation and administration of the certification process by the CCRTGE, as well as the other advantages described in Section 2(B) of the report. Over the next 1-2 years, it is intended to phase out the paper-based recording of colonoscopic training and migrate it fully to the web-based one. This will be funded from GESA’s resources, with cost-recovery largely met from the fees levied for certification.

Self-Sustaining Training Programs

The various training activities that have been developed as a result of the Project have been judged to be highly successful, by both trainers and trainees. Evidence for this is provided elsewhere in the report. It will be important to build on the success of the Train-the-Colonoscopy Trainer program, and the workshops and courses for the trainees described in Section 2 to ensure their viability and further expansion. Uptake of the training courses is already high. Some trainee groups (e.g. surgeons) have been under-represented, perhaps because there are so many other technical skills that they have to develop during their Fellowship training years. However, as the value of the colonoscopy courses has become more widely known, the number of such trainees is increasing. At the most recent NETI Basic Colonoscopy course, five young surgeons were included.

The Commonwealth funding for the Project has been critical in getting all these training activities off the ground. They will now need to be self-funding, and the section on budget below indicates how this will succeed.

Recertification of Competency in Colonoscopy

This part of the Project is breaking new ground in Australia. Once a health professional has been recognised to have competency in a particular area or procedure, there are few precedents (other than a general requirement to

demonstrate participation in some broad continuing professional development program) for needing to demonstrate ongoing competence in a particular procedural skill. As a result of this Project, the stage is set for the introduction of a voluntary process of recertification of competency in colonoscopy in Australia. The standards and mechanisms for this have now been agreed by the recertification committee set up during the Project. Trialling of these is about to commence. The results will then be evaluated and the standards and mechanisms modified if necessary. The recertification process is then expected to be made available to all certified colonoscopists in late 2012 or the first half of 2013 (in a staged fashion so that future renewals occur evenly throughout each triennium). This will also need to be self-funding, and the mechanisms for this are indicated in the next section.

Achieving Self-Sustaining Funding for the Future Activities of the Programs

The pilot programs set up under the Project have provided information that is also needed for setting budgets for sustaining them when this Commonwealth funding ceases. Accurate data on the costs of each component, and the size of the ‘market’ for each has been assembled. It is likely that the number of trainees participating will increase somewhat with time, so that the marginal cost of running courses will decrease a little. For this reason, the budget estimates are likely to be conservative.

Fees will be levied for both the courses and the maintenance of candidates’ data on the certification and recertification websites. Industry support has also been obtained during the pilot phase and some ongoing support from this source is likely in future, but has not been relied on in setting the initial budgets for the sustainability phase. This budget, which has been approved by GESA Council at its most recent meeting, is shown in [Appendix 16](#).

Validation of the Training Model Funded under a Separate Commonwealth Project

Some of the training methods that have been piloted in this project have drawn on data assembled under a separate Commonwealth grant to the University of Queensland, titled “*The Development and Evaluation of a National Colonoscopy Training Program*”. While there is considerable theoretical and some ‘in the field’ evidence for the efficacy of these, NETI/GESA could subsequently contribute to further ‘in the field’ analysis of the efficacy of various components of training. This would, however, require a future funding stream.

Conclusions

GESA has been very pleased to partner with the Commonwealth in this project, which it believes is of national importance to the health of Australians. It concludes that all of the components of the training program have been valuable, that it strongly supports the improved processes for certification and the evolving process for recertification in colonoscopy, and will underpin the continuation of these via the budgetary mechanisms described above.

ACKNOWLEDGEMENTS

GESA would like to thank all the people who have made the success of this project possible.

Any project of such complexity and magnitude can never succeed without their skilled dedicated and selfless support this vitally important medical project could not have proceeded and achieved its current success. In particular we would acknowledge the important contributions made to this project by the following:

- Professor Neville Yeomans, Former Dean, University of Western Sydney
- Ms Rebecca Bartel, Ceutica Medical Communications
- Dr Katie Ellard, Gastroenterologist, Sydney, New South Wales

FACULTY

- | | |
|----------------------|----------------------|
| Dr. Mark Appleyard | Dr. Garry Nind |
| Dr. Phil Barnes | Dr. Keith Noack |
| Dr. Cameron Bell | A/Prof. Ian Norton |
| Mr. Stephen Bell | Dr. Peter Prichard |
| Dr. Michael Bourke | Dr. David Rubenstein |
| Dr. Alex Boussioutas | Dr. Mark Schoeman |
| Dr. Gregor Brown | Miss Susan Shedda |
| Dr. John Colman | Dr. Rajvinder Singh |
| Dr. James Daveson | Dr. Miles Sparrow |
| Dr. David Devonshire | Dr. Daniel Stiel |
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| Dr. Richard La Nauze | Dr. Biju George |
| Prof. Kate Leslie | Dr. Sarah Cho |
| Mr Andrew Luck | Ms Jo Benhamou |
| Dr. Finlay Macrae | |

VENUES

- The Royal North Shore Hospital – Sydney
- Lyell McEwin Hospital – Adelaide
- The Royal Melbourne Hospital – Melbourne
- The Royal Adelaide Hospital – Adelaide
- The Prince Charles Hospital – Brisbane
- The Alfred Hospital – Melbourne
- St Vincent’s Hospital Melbourne
- The Charles Gairdner Hospital – Perth
- The Royal Brisbane Hospital – Brisbane

And, finally, a special thanks to the skill and dedication of the GESA (administrative office staff) who have unstintingly administered and managed this project from its first incipient stages up to the present time.



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