European Society of Gastrointestinal Endoscopy

ESGE

ESGE Quality Improvement Committee Strategy

Introduction

This document outlines the strategy to be overseen by the ESGE Quality Improvement Committee (ESGE QIC). Quality Improvement is a dynamic process and as such the strategy details will evolve over time, although the broad quality remit will not.

Aims

The aims of the strategy are to ensure that the objectives of the ESGE QIC are fulfilled, namely:

- To improve the global quality of endoscopy and the delivery of patient-centred endoscopy services
- To promote a unifying theme of quality of endoscopy within ESGE activities, achieved by collaborating with other ESGE committees and working groups and underpinned by a clear quality improvement framework
- To assist all endoscopy units and endoscopists in achieving these standards

Collaboration with other ESGE committees

To achieve this central tenet of ESGE, quality must lie at the heart of ESGE initiatives. A summary table of key collaborations is detailed below. More specific examples are detailed later in this document.

	ESGE QIC Committee collaboration
Education Committee	To assist in the revision of aims and outputs for educational activities to incorporate quality driven issues, including in ESGE courses, e-learning and endoscopy training
Guidelines Committee	To assist in the development of a “policy for guidelines”, making explicit reference to quality and identifying/discussing where appropriate: • key performance indicators (KPIs) and where possible a quality standard • training requirements • areas for future research
Research Committee	To assist in the development of a research strategy prioritising areas that improve quality of endoscopy, either directly or indirectly
Other working groups	To collaborate with established working groups on quality issues and to provide support and guidance on quality when new working groups are set up To suggest new working groups to facilitate the achievement of ESGE QIC goals

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Quality Improvement Framework

Quality in endoscopy can be split broadly into 3 components:

1. Quality of independent endoscopists
2. Quality of endoscopy training
3. Quality of endoscopy services (e.g. endoscopy waiting times, patient-centred service)

The ESGE QIC **quality improvement framework** covers these 3 areas. This will be the key, overarching framework that will be overseen by the ESGE QIC committee.

1. Quality of independent endoscopists

The ESGE should produce a **Quality Standards in Endoscopy guideline**. These should cover all established endoscopic procedures, namely:

- Lower GI endoscopy
- Upper GI endoscopy
- Pancreatobiliary
- Small bowel

Consideration should also be given to developing guidance on endoscopic non-technical skills (ENTS).

The ESGE CRC screening working group has made great progress on the development of colonoscopy quality standards and should be seen as the exemplar model for this. Similar working groups should be set up for other endoscopic procedures.

As other techniques emerge, these should initially be covered by a position statement (coordinated by the guidelines committee), until such a time that a formal guideline can be developed. Further suggestions on how to present quality standards are detailed in appendix 1.

Guidelines should be **reviewed every 3 years**.

ESGE **guidelines for supporting underperforming endoscopists** should also be developed.

Key Actions:

a. Produce Quality Standards in Endoscopy Guidelines
b. Develop Guidelines for Supporting Underperforming Endoscopists
c. Ensure future guidelines contain sections on quality standards and training where appropriate, along with areas for future research

2. Quality of endoscopy training

ESGE should develop a **framework for basic training** in endoscopic procedures. The aim of this should be to ensure that all trainee endoscopists develop a safe, effective and (wherever possible) standardised technique, as soon as possible in their training.

ESGE should consider running a series of such **courses**, but should also encourage other organisations to adopt/incorporate the ESGE framework for basic training in their courses, as

ultimately it will be the dissemination of this framework which will have the greatest reach into endoscopy units across Europe.

Key Actions:

a. Produce Quality Framework for Basic Endoscopy Training
b. Discuss the development of basic endoscopy training courses
c. Ensure other ESGE courses and educational activities are aligned with the training framework

3. *Quality of endoscopy services*

The ESGE should develop a **framework for the quality of endoscopy services**, covering all areas of the service including equipment, decontamination, waiting times, patient experience and endoscopy quality. The aim of this document is to set a minimum standard for an endoscopy service, and to permit endoscopy units to measure their services against this framework.

ESGE should consider running **courses** aimed at assisting endoscopy unit in improving service quality. The courses should be multidisciplinary, including clinicians, nursing staff, managers and admin staff. A requirement of the course may be to complete a baseline report card, with an expectation that subsequent annual report cards will be returned to demonstrate whether progress has been made.

In the future, the ESGE may wish to consider developing a system for **accrediting endoscopy units**. This would help drive up endoscopy quality. However ESGE would have no power to mandate this, therefore it would have to be done on a voluntary basis and would be complex and challenging. It is likely that ESGE's reach into different countries is highly variable, hence uptake is likely to be very low, at least initially.

As an initial exercise, it would be useful to know **how many endoscopy facilities there are** in each country. Each country's ESGE representative could be tasked to determine this.

Key Actions:

a. Develop Quality Standards for Endoscopy Services
b. Undertake a survey of current endoscopic facilities within ESGE territory
c. Discuss the development of courses to assist endoscopy service development
d. Discuss the development of a service report card/accreditation

Appendix 1 – Endoscopy quality standards

ESGE guidelines should make explicit reference to monitoring of Key Performance Indicators (KPIs) and, where possible, indicate quality standards (QS), citing a "minimum standard" and a "target standard" For example:

KPI: caecal intubation rate at colonoscopy (unadjusted)

- Minimum QS >90%
- Target QS >95%

The QS may vary according to procedure: for example the QS for adenoma detection rate (ADR) will be higher in FOB diagnostic colonoscopy compared to symptomatic colonoscopy.

Occasionally with a KPI, no clear QS (cut-off figure) may exist (for example, patient comfort), yet it may still be considered important to measure. These should be indicated as "auditable outcomes" (AOs) and identified as an area in need of further research/evaluation.

Some KPIs may relate to broad procedures (for example caecal intubation rate), whereas others may relate to specific indications (for example the optimal biopsy strategy for Barrett's surveillance).

KPIs should be clear, objective, reproducible and realistic. They should also be practical to measure.

On occasion, it may be prudent to have more than one KPI for a particular aspect of endoscopic practice. For example, whereas ADR is considered the current gold standard measure for neoplasia detection, in certain situations it may be impractical or impossible to measure this routinely, thus the provision of alternative measures such as polyp detection rate or polypectomy rate may be appropriate. In these circumstances, a primary (preferred) KPI should be identified. Pros and cons of each measure should be discussed. It is suggested that the QS threshold of secondary KPIs should err towards a higher level to compensate for this, with a recommendation that if an individual's performance is below the secondary QS, the first course of action should be to assess the primary KPI. SO, for example if an individual's polyp detection rate falls below its QS of say, 25%, the first course of action would be to calculate the individual's ADR.

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