European Society of
Gastrointestinal Endoscopy

ESGE

Supporting Information 2

Delphi Voting process
Quality Improvement Committee
Endoscopy services working group

Reports exported from online voting platform
developed by Dr Stuart Gittens (ECD Solutions)

Working Group: Endoscopy service Round 1

Section: Leadership and organisation

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

Editorial Comment:

There was concern about the use of the word competent and how this might be defined. One person (ID 56) referred to one of the publications on leadership on the website. It is possible to define competence of leadership in the same way as it is possible to define competence endoscopy. It is hoped that this statement will encourage endoscopy services to be more systematic in the selection and assessment of its leaders. No change to statement

Evaluative Text:

accountability here refers to who the team is accountable to for governance (essentially quality and safety). In a hospital there will usually be well-defined pathways for governance but in stand-alone units it may not be so clear ? but it is important. A leadership team should create a culture of high quality and safety, and one that is patient centred.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Leadership team, with defined roles and responsibilities and accountability Is this locally, regionally or nationally?	No defined leadership team	Continued improvements in technique, quality and safety of endoscopy [(Detection, treatment, progression to advanced cancer.) This outcome may not need to be described explicitly for each performance measure, but possibly an overarching statement of the ultimate aim of high-quality endoscopy services should be included in the manuscript.]

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	12 (50%)	12 (50%)	4.5	100%

Comments:

User: 52 [2016-10-14 11:05:22] - add in well-trained leadership team
Roland Valori: I have included competent rather than well-trained

User: 56 [2016-10-14 11:05:22] - I also think it is important to make sure that these leaders have a mindset that is clear about Quality and why Quality is important. It is important that this culture of Quality and its importance be rooted in the leader. Maybe training or an exam for the leader is important or a certificate that he/she can take. I've had trouble installing this culture of Quality in my own Endoscopy unit not only to my Endoscopy Nurse manager but even to my Chief of Endoscopy and I have given many lectures about the subject to my team.
Roland Valori: While I agree with these sentiments being specific about these things in a recommendation is quite difficult. We certainly cannot say that we recommend courses: one problem would be what course is suitable. I have changed the note to reflect the comment about culture

User: 57 [2016-10-14 11:05:22] - I agree with User: 56, but I think this is a more common problem every where in medicine

User: 76 [2016-10-14 11:05:22] - I do agree on the importance of identification of a leadership team on quality issues overall (improvement, motivation, commitment); also some formation initiatives (maybe at a national level) for the leaders could be proposed, in order to provide a shared "backbone" for endoscopists' training and education.
Roland Valori: While I agree that there should be national initiatives to support the recommendations we make it is not the remit of this working group to make national recommendations. Nevertheless we might make some general recommendations in the paper about who should do what next.

User: 68 [2016-10-14 11:05:22] - New developments of operative endoscopy is no longer an occasional tool for most gastroenterologists; it is a serious (minimally invasive) surgical procedure for a few. Therefore, in my opinion, leaders of highly specialized operative endoscopy units (centers) must have competence most of the difficulty level C procedures including difficult ERCP, difficult polypectomy, mucosectomy, EUS, with a reasonably long time of practice and high level of competence. Similarly to interventional cardiology, we also should describe a voting and approval system how to delegate these national experts for the leadership of these high volume endoscopy units, irrespectively of the preference of hospital administration, to approve patient safety.
Roland Valori: I agree about operative endoscopy but do not think that the leader need do this work. The leader needs , above all else leadership competence. I know many highly skilled technical endoscopists who do not make good leaders and vice versa. your second point about national direction of where specialised endoscopy should take place is well made and I entirely agree there should be fewer high volume centres for this work. it is beyond the remit of this guideline to recommend this but we might mention it in the paper.

User: 57 [2016-10-27 08:17:32] - I do hesitate on the choice of words, in the statement iit is written competent leadership and in the comparator defiend leader ship. To me these two terms are different, a defiend leadership is not necessarily competent. And we do not state what we mean with competent. Consequently I think that in the statement competent should

be replaced by defined

User: 56 [2016-10-30 06:39:37] - Just read the article of Dube et al.: The last part of the article is related to leadership. I like what she says that.... " Leadership differs from management. Leaders are visionaries that set goals and communicate new directions" But the real question is what if the leader is not motivated to embrace this culture? How can you teach a person like this? What to do? I also liked Figure 1 as it is a great way to summarize what competence is all about and I think we all should read it and actually show it to our colleagues. I personally am trying to become "consciously competent".... I also read the article by Valori et al. Leadership and team building in gastrointestinal endoscopy : What I really liked about the article is that it is giving us a framework in an organized manner on how to improve our endoscopy unit and I quote: " This chapter will first of all consider what constitutes a good service, including providing high quality training, and then reflect on how the endoscopy team delivers such a service. It will then explain how effective leaders develop great teams to deliver an excellent service. It will explore the extent to which leaders are constrained or supported by the organisations they work within. Finally, it will review the wider context, especially the external drivers affecting endoscopy to improve quality such as standards and methods to enforce them." I think we should emphasize in the Guideline "Very Important articles" that are a must read.... Similar to what they do in the journal "Current opinion in Gastroenterology" and I will add in the comment section as much as I can identify articles that are a " must read" Another must read is the ASGE 2015 article on 5 Quality indicators common to all GI endoscopic procedures Rizk et al. In summary, I fully agree with the statement with some suggestions: 1) To specifically read the article of Valori et al. as it gives a road map on what is important. The reason I say this is that I think that our duty in writing the guideline is to identify to the readers a roadmap on how to achieve this and I think the Valori article addresses this

User: 60 [2016-11-06 12:57:31] - I agree. I could be a team or a single person (private endoscopy centers).

---------- End Statement ----------

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

Editorial Comment:

Feedback raised concern about how the 'necessary resources' are defined. An endoscopy service should first of all determine the demand it expects and what level of service provision is required to deliver indicated by European and National regulation and guidance. Then it can define the resources it needs. No change to statement

Evaluative Text:

there is intense pressure on endoscopic capacity in most countries and resources are constrained everywhere. It is important to maximise use of resources (and many services will be under intense pressure to do more for less) but this can put patients at risk and affect quality and patient experience. This recommendation recognizes the tension.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Strategy and monitoring/ feedback for organisation, maximisation of resources, service delivery, appropriate utilisation.	No coherent strategy for organisation, monitoring, feedback. maximisation of resources, service delivery, appropriate utilisation. Inappropriate pressure on endoscopic resource, including personnel.	Patient satisfaction, quality and safety. Personnel retention problems.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	16 (64%)	9 (36%)	4.4	100%

Comments:

User: 52 [2016-10-14 11:05:22] - to find good and regular resources and to organize its maximum utilization.
Roland Valori: point made and recommendation changed

User: 59 [2016-10-14 11:05:22] - Concerning this point (pressure-tension about quality and profitability , I suggest that we add a comment in the introduction about the human resource

needed to develop and maintain what we are recommending. As for all other Quality Process, we recommend a lot of data recording and analyse, and then to be fed back. This need human resource. If assurance company or government agency use our recommendation, they need to know before that it has a cost.
Roland Valori: agreed: this is so important I have created a new recommendation

User: 92 [2016-10-21 13:20:27] - concerning this point, i think we need to put in mind the maximum capability and performance of the internal customers including endosopists as well as the resources in developing countries.

User: 56 [2016-10-30 07:00:16] - Again I would like to point out that we should tell the readers what these "Necessary resources" are , and I think the Valori article addresses this very nicely. I think that they need to be guided... I think that in my country, we can benefit from all the many internet websites that the Valori article mentions as it provides a framework and it is for free on whoever wants to use it ... This would cost a lot of money should you bring consultants to try to organize this for you..... Not sure if everyone agrees with me on this.... In Summary, I agree with the statement ....

User: 57 [2016-11-01 14:14:29] - Optimizing the use of resources includes avoiding non-indicated examinations

User: 93 [2016-11-03 09:15:59] - I do believe that we need to extablish what is the workload of a gastroenterologist. I mean how many gastroscopies has he perform per day, per hour... In Italy we did that and I would find something common in Europe, as we are in European Community

User: 66 [2016-11-06 03:59:14] - I think we have to explain what we mean by "necessary resources".

User: 101 [2016-11-10 04:22:45] - I miss "Staff safety" in this statement. In addition to patient safety, recourses should also be used to ensure maximum safety of staff (e.g. This starts with simple thinks like PPE and ends with complex issue like use of x-ray

---------- End Statement ----------

Section: Facilities and equipment

2.1 We recommend that the endoscopy service carry out an assessment of the facilities and equipment required to deliver the service at least annually.

Editorial Comment:

One person voiced concern about 'at least annually' and recommended regularly. Regularly could be every ten years so at least annually has been kept. No change to statement

Evaluative Text:

no time interval has been stipulated but at least annually would be appropriate. An endoscopy unit cannot function without the necessary facilities and equipment

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Annual assessment of facilities and equipment required to deliver the service. Does this also build in a requirement to assess standard of equipment against new guidelines for example high-resolution endoscopes are now recommended in many guidelines?	No scheduled assessment of facilities and equipment required to deliver the service. No resources available to carry out assessment.	Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	3 (13%)	8 (34.8%)	12 (52.2%)	4.4	87%

Comments:

User: 57 [2016-10-14 11:05:22] - I think that "at least annually" should be stated
Roland Valori: I have changed the recommendation to reflect this

User: 66 [2016-10-14 11:05:22] - We can replace it (at least annually) to the recommendation statement
Roland Valori: changed

User: 92 [2016-10-21 13:39:28] - I suggest replacing " at least annually" with "regularly" to be done according to the nature of each unit or organization and also we can recommend KPIs for each services to control these processes.

User: 56 [2016-10-31 03:44:33] - I will strongly agree with this recommendation even though the studies that were mentioned are not randomized to show that at least annually makes a difference but it makes perfect sense that that the endoscopy equipment and facilities need to be checked and that quality assurance of the equipment be implemented to the best international standards. The only study that talks about this is the ESGE Segnan 2010 Quality article and a good roadmap for the endoscopy facilities to follow

---------- End Statement ----------

2.2 We recommend that the endoscopy service has a planned programme of inspection, calibration and maintenance of its clinical equipment according to the manufactures? advice

Editorial Comment:

It was suggested we include something about national regulation. Statement changed

Evaluative Text:

this is a basic requirement to minimise the risk of equipment failure

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Planned programme of inspections calibration and maintenance, minimally according to manufacturer specifications. I mention minimally because it may be necessary to inspect more frequently or regularly depending on heavy usage or not, and other factors That might include tests aimed at ensuring complete disinfection.	No planned program	Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (4.5%)	6 (27.3%)	15 (68.2%)	4.6	95.5%

Comments:

User: 57 [2016-10-14 11:05:22] - According to the manufactures advice ??
Roland Valori: agreed and recommendation has been altered

User: 66 [2016-10-14 11:05:22] - This statement needs more clarification and explanation. For example should we mention a time interval or limitation?
Roland Valori: according to manufacturers' advice

User: 92 [2016-10-21 13:44:59] - Not only clinical equipments, non clinical services can affect

the patient outcome more than clinical factors.

User: 56 [2016-10-31 03:48:37] - I will strongly agree with the statement however I should point out that the manufactures’ advice could also be biased and that the endoscopy facility should look at other manufacturers and see what is the norm

User: 101 [2016-11-10 04:33:50] - I agree with the statement, but would like to add " ... according to to national law / recommendations". National law recommend the validation of reprocessinf cycles follwoing a standardised programme, technical facilties need to checked following national regualtions etc.

---------- End Statement ----------

2.3 We recommend that the endoscopy service has a plan to address shortfalls, replacement and purchase of facilities and equipment

Editorial Comment:

No substantive comments. No change

Evaluative Text:

planning equipment replacement is a basic requirement

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Annual review of servicing, replacement or purchase of facilities and equipment. See also 2.1 above, assess standards against new guidelines and advances.	No scheduled reviews	Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (4.5%)	9 (40.9%)	12 (54.5%)	4.5	95.5%

Comments:

User: 57 [2016-10-14 11:05:22] - Agree but do we need to set some minimum suggestions for replacement of essential equipment like endoscopes? Example 4000 examination for a colonoscope?
Roland Valori: I really do not think we can recommend maximum numbers of use. I would point out that kit which is well looked after will last much longer than poorly cared for equipment

User: 56 [2016-10-14 11:05:22] - I also recommend that Industry representatives understand why Quality is important and why replacement of a damaged scope is important to the Quality and efficiency of the Endoscopy unit. Maybe a training module or a series of lectures be given to industry representatives about Quality and why their input is important because at the end everybody wins.
Roland Valori: while I agree I am afraid we cannot make recommendations for industry

User: 56 [2016-10-31 03:53:25] - Strongly agree and I also agree that the industry should

understand why quality is important in addition tot he hospital CEO,CFO and COO as better quality is good for everyone

---------- End Statement ----------

2.4 We recommend that decontamination facilities, equipment and processes meet national and/or European standards

Editorial Comment:

There were suggestions to insist services follow ESGE guidance on decontamination. It is not possible to insist on following European guidance. In the note it has been emphasised that services should follow ESGE guidance if there is no national guidance. Suggestion to have named person included in note. No change to statement

Evaluative Text:

a basic requirement

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Provision of decontamination facilities equipment and processes that meet national and/or European standards.	Failure to provide decontamination facilities.	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	5 (22.7%)	17 (77.3%)	4.8	100%

Comments:

User: 66 [2016-10-14 11:05:22] - A must?

User: 52 [2016-10-14 11:05:22] - add materials.
Roland Valori: equipment covers materials

User: 68 [2016-10-14 11:05:22] - I suggest here more strict regulations, including documentation and personal responsibility of the endoscopy unit medical leader for the correct endoscopic reprocessing, cleaning and also about the visibility and strict regulations of the use endoscopic accessories, including the prevention of reprocessing of any single use device.
Roland Valori: I do not think we can dictate requirements beyond national or ESGE

regulations but we might mention not using single use more than once in the note

User: 56 [2016-10-14 11:05:22] - The problem with this is that there are still a lot of Endoscopy unit especially here in my country where scopes are still washed by hand and not left enough time in reagents to decontaminate. This needs to be enforced and even though it is a basic requirement, we still have a long way to go?
Roland Valori: I would hope that the guideline will help enforcement

User: 92 [2016-10-21 13:54:15] - i suggest the presence of a responsible competent person for infection control in each facility.

User: 57 [2016-11-01 14:22:05] - Shall we consider ESGE recommendations as a minimum standard and that an alternative national standard must be more rigorous?

User: 93 [2016-11-03 09:22:03] - I prefer to have and to follow ESGE recomendation

User: 58 [2016-11-07 13:45:36] - You can recommend the guideline of ESGE/ESGENA cleaning and desinfection.It include manuel cleaning/ single use devices etc. I would also recommend a dedicated person who is responsable for cleaning etc

---------- End Statement ----------

Section: Quality

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

Editorial Comment:

No subtantive suggestions for change to this statement. No change to statement

Evaluative Text:

capturing and presenting performance data is essential for a unit to be able to demonstrate its endoscopists reach required standards, and to monitor improvements if they are required. The ESGE and some national bodies recommend the minimum key performance indicators that should be captured.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	No: Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	9 (39.1%)	14 (60.9%)	4.6	100%

Comments:

User: 76 [2016-10-14 11:05:22] - It may be proposed to consider the adoption of structured reporting programs allowing to easily calculate performance indicators to implement monitoring and feedback programs for endoscopists. This path should be easy as a non-automated system would be cumbersome and poorly applied during everyday busy practice. Roland Valori: I agree and the ESGE has already published guidance on minimum requirements for endoscopy reporting systems. I am unsure whether this guidance included recommendations on outputs.

User: 52 [2016-10-14 11:05:22] - as well as archiving.
Roland Valori: not sure what is suggested here. Archive what? I agree image storage for later review. Is this what was meant?

User: 57 [2016-10-14 11:05:22] - Should we also make a suggestion that a national service for retraining should be organised?
Roland Valori: beyond the scope of the guideline but we could make a reference to this in the implementation recommendations

User: 56 [2016-10-14 11:05:22] - The question is how to do that in an effective and non ? intimidating manner? It was easy for a country like the UK to implement this and force Endoscopists that want to do screening for CRC to pass a written and a practical exam. All this thanks to the efforts of Dr. Valori who has been a champion and a leader in the effort to improve Quality of Endoscopy in the UK and around the world. But in a country like [....], how are you going to enforce this? In the UK, it is easier as you have the NHS which is a 1 payer system. The problem that I think that you also have in the UK, is that it did not address the problem of what happens to those physicians that do not pass the above mentioned exams? Do we still tell them that it is ok for you to go and do endoscopy even though you do not meet the criteria for screening? We have an issue here that needs to be solved. This is also an issue that even the U.S. did not address. Now they have the P4P (pay for performance) measure that penalizes you if you do not meet certain Quality indicators. Is this the way to go?
Roland Valori: Of course I could write a book about this. Nevermind the health care system the key issue is who is prepared to provide a lead on improving quality. In the UK the professional groups decided to take a lead and enforce quality and not leave it to government, hospitals or other agencies. The responsibility question was debated in the ESGE QIC committee and there was a strongly held view that professional societies were 'academic' and not responsible for enforcing quality. I would be interested in what others thought about

User: 66 [2016-10-14 11:05:22] - What are the performance indicators? I think we need to explain it
Roland Valori: I have changed the note

User: 56 [2016-10-31 06:09:10] - Well I strongly agree with this statement and this has been proven by many evidenced based articles in many journals and duplicated I also believe that it the duty of the ESGE/ASGE etc.. to police this or other national societies. In USA, there is the P4P program (Pay for Performance) that penalizes doctors if they do not meet certain quality parameters. It is sad to say that this has to happen for us physicians to police ourselves.

User: 74 [2016-11-01 15:40:42] - I certainly agree with all that it is very difficult to implement performance measures in a national level. In a country such as Spain where there are 17 independent regions, the government would not undertake such a responsibility, probably because of the financial support it would require. Therefore national societies have been organizing training programs especifically on quality for colonoscopy in CRC screening since 2014, which of course are not compulsory and therefore, those endoscopists who do not participate cannot be penalized..Probably an individual feedback would be an option.

---------- End Statement ----------

3.2 We recommend key performance indicators are fed back to and discussed with endoscopists on a regular basis, and plans for improvement, when indicated, with objectives are agreed with the individuals

Editorial Comment:

Feedback suggested the statement should say at least annually. The note, which has been modifed slightly, covers this question. Feedback frequency depends on the metric and whether there are perceived problems. It would be wrong to address problems identified by staff or patients several months after they occur. Also there were suggestions of making the review of performance data open so everyone knows about everyone else's performance. Difficult to recommend in a statement at this stage but mentioned in the note. Minor change to the statement

Evaluative Text:

systematic reviews indicate that when health professionals are given data on their performance they will, in most circumstances, improve. There is evidence that this is the case in endoscopy. However, improvement in response to feedback is highly variable because some may not consider it necessary to improve and others may not know how to get better: not all endoscopists will automatically get better when presented with performance data. Some may not consider it necessary and others may not know how to get better. So a discussion and a plan, with agreed objectives is necessary if they are to improve It is expected that the endoscopist member of the leadership team will conduct this discussion. This may include further training that may have to be sourced elsewhere.The frequency of feedback and discussion depends on the metrics for the procedure and the sample size required to know whether performance is below acceptable levels. It is recommended that feedback occurs at a minimum of six month intervals, more frequently if concerns have been raised about performance from patients, endoscopy staff or other endoscopists.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	No: Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%

0 (0%)	0 (0%)	3 (13.6%)	7 (31.8%)	12 (54.5%)	4.4	86.4%

Comments:

User: 66 [2016-10-14 11:05:22] - I think a team ,leaded by the endoscopist, may be responsible these improvements
Roland Valori: agreed. note

User: 56 [2016-10-14 11:05:22] - See comment of User 56 to 3.1

User: 52 [2016-10-14 11:05:22] - We recommend key performance indicators are fed back to and discussed with endoscopists on a regular basis, and plans for improvement and training annually, with objectives are agreed with the individuals
Roland Valori: I have added something in the comment

User: 92 [2016-10-21 14:04:31] - i suggest to fed back to whom they concern or belong of the working team including endoscopists.

User: 56 [2016-10-31 06:12:18] - Strongly agree Dr. Kahi in Indiana published a great article regarding report cards and how certain quality indicators improved when this card was instituted I wonder whether we can mention something about that or maybe this is too specific?

User: 57 [2016-11-01 14:29:38] - I think An open discussion within the endoscopy unit regarding all endoscopists performance is the best way to improve quality and create a safety culture

User: 93 [2016-11-03 09:45:17] - I also agree that open discussion within the Endoscopy Unit regarding all endoscopists performance is the best way to improve quality

User: 60 [2016-11-06 13:07:08] - I would say "at least annually".

User: 58 [2016-11-07 13:53:47] - agree with the suggestions, at least annually.

---------- End Statement ----------

3.3 We recommend that the endoscopy service ensures that plans for improvement have been effective and, if not, that there is escalation of action and notification to the relevant governance structure within which the service is situated

Editorial Comment:

There were concerns about the clarity of this statement and it has been reworded

Evaluative Text:

to protect patients an endoscopy service has to check that is improvement plans have been effective and if not that something is being done about it. The way to show an improvement plan has been effective is to set some measurable objectives for the plan and then ensure those objectives have been achieved within a set timescale. Clearly it is unacceptable if the plan is not achieved. If not then there has to be a review of why not and if the reason is beyond the control of the endoscopy team then the problem has to be escalated ?up? to someone who does have the influence and control to do something about it. For example, there may be an endoscopist who refuses to improve his/her performance, or who has unacceptably bad behaviour when in the unit which he/she refuses to, or cannot change. The endoscopy unit may not directly employ this endoscopist and the unit may have.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Audit cycle of whether the endoscopy service is: Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	No: Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Endoscopist training (and sanctions? Do we want to even consider this?!)

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	4 (18.2%)	11 (50%)	7 (31.8%)	4.1	81.8%

Comments:

User: 57 [2016-10-14 11:05:22] - I think that this is not specific enough and not easy to understand
Roland Valori: I have explained further in the accompanying note

User: 92 [2016-10-21 14:11:19] - i suggest to replace "plans" with corrective and preventive actions for improvement.

User: 56 [2016-10-31 09:30:09] - I strongly agree .... I still think that we should direct the endoscopy units on how best to do that and mention to them relevant articles that they should read to give them a road map

User: 93 [2016-11-03 09:59:15] - I also think that this is not specific enough and not easy to understand

User: 60 [2016-11-06 13:09:55] - In my opinion, statement is not very understandable.

---------- End Statement ----------

3.4 We recommend it is made clear which diagnostic and therapeutic procedures endoscopists are competent and allowed to perform in the service.

Editorial Comment:

Concerns have been raised in feedback that we should have more guidance on competnce and be clearer how this is defined. This has been discussed in the overarching ESGE quality committee and it was agreed that this should be the subject of future guidance and we have been instructed not to make recommendations at this stage. The current recommendation is the first step in raising an issue which is often not considered and which puts patients at risk. Also there has been a suggestion we should be recommending how many procedures it is reasonable to expect a person to do. This is well beyond the scope of this guideline. No change to the statement but clarification of these important issues in the note

Evaluative Text:

an endoscopist performing a procedure he/she is not trained and competent to perform will put patients at risk and is therefore a major governance issue. We suggest a register is kept of who is allowed to do what in the endoscopy unit. This will empower nursing staff and other endoscopists, ideally through the leadership team, to challenge endoscopists who perform procedures they do not have permission to do. This does raise issues of who is responsible for governance..Local services? professional bodies, national health services? health insurance companies?

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Register of which personnel are deemed competent and adequately trained in individual endoscopy procedures. This is slightly problematic because there are no standards definitions by which a person who is doing at endoscopy is known to be adequately trained or competent.	No register of trained competent endoscopists	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Endoscopist training (and sanctions? This does raise issues of who is responsible for governance.. Local services? professional bodies, national health services? health insurance companies?

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%

0 (0%)	0 (0%)	1 (4.5%)	8 (36.4%)	13 (59.1%)	4.5	95.5%

Comments:

User: 92 [2016-10-21 14:21:48] - i suggest that we can recommend that each organization should have a process of credentialing and privileges that ensure competency of all medical team.

User: 56 [2016-10-31 09:40:14] - I strongly agree But pertaining to the Editorial note, this particular endoscopist will probably say, well how come you let a surgeon perform a surgery he or she has not performed in years or an internist who has not treated a particular disease for many years yet you won't let me perform an endoscopy and they are right to do that --- Which is why I think that this has to apply to the whole system and the whole health field establishment and not only to endoscopy --- I realize that this guideline is for endoscopy units only and we are not talking about anything else -- But I thought I would mention this --- I also think we should mention something about an important article that is a must read by Dube et al. Acquiring and maintaining competency in gastrointestinal endoscopy

User: 95 [2016-11-01 04:13:36] - I recommend that additional definitions are placed in each instititution about who is permitted to perform certain procedures. There should be mechanisms that well descirbe the pathways to acquiring certificates for performing procedures, but also pathways for withdrawing such certificates according to previously mentioned statements. Such decisions should be accepted by professional bodies.

User: 57 [2016-11-01 14:42:53] - There are some challenging issues for patients living in rural areas and having a long traveling distance to their low volume local hospital(more than 5 hours)and even longer distance to tertiary referral hospital and whether one can accepts poorer performance to reduce the burden of long distance travel.

User: 93 [2016-11-03 10:17:51] - I believe that shoud be Endoscopy Units (depending on the number of procedure extimated) in which should be gastroenterologists that cover the procedure 365 day per year (ERCP, EUS...) performing each a right number of exams. I mean that the number of endoscopists depends on the typology and numbers of each procedure expected in that unit... and should be numbers suggested by ESGE

User: 66 [2016-11-06 13:26:42] - Strongly agree. It is also important for patient safety and also for endoscopist for possible legal problems. But the challenging thing is that how can we manage (or how can we be sure about) the certificate programme. This is thought as a governance problem but I'm not sure if all countries have formal guidelines or official issues about "who can perform endoscopy?". In some countries, some practitioners except Gastroenterology can perform endoscopy without formal education programme. A statement about this issue may be useful.

User: 83 [2016-11-07 03:52:19] - depends upon each organoisation

---------- End Statement ----------

Section: Safety

4.1 We recommend endoscopy services identify all potential risks to patients and staff and implement policies and procedures to mitigate them

Editorial Comment:

No significant commments other than include sign-in, team time out, sign out. Considered too specific. No change to statement

Evaluative Text:

the best way to avoid risks is to prevent them. The best way to prevent risks is to know what they are and put in place processes to avoid them. For example having protocols for patients on anticoagulants and in room check lists (?time out?). While there will be some common risks to patients different services will have different risks. Services are referred to other guidance on safety such as antibiotic and anticoagulation guidelines.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Identification of potential risks Protocols and checklists for potential risks How wide is this does it include general safety such as safe working practices and biohazards? Could this be termed as standard operating procedure manuals produced, reviewed and kept up-to-date	No standard operating procedures	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	7 (31.8%)	15 (68.2%)	4.7	100%

Comments:

User: 81 [2016-10-14 11:05:22] - One of the biggest risk is contamination of endoscopes (cleaning and hygiene): A recall system should be possible by linking of the endoscope to the patient. "Swiss cheese model": the anatomy of an error. Reason proposed what is referred to as the "Swiss Cheese Model" of system failure. Every step in a process has the potential for failure, to varying degrees. The ideal system is analogous to a stack of slices of Swiss cheese.

Consider the holes to be opportunities for a process to fail, and each of the slices as "defensive layers" in the process. An error may allow a problem to pass through a hole in one layer, but in the next layer the holes are in different places, and the problem should be caught. Each layer is a defense against potential error impacting the outcome. Figure: medical Example. The original source for the Swiss Cheese illustration is: "Swiss Cheese" Model ? James Reason, 1990. The book reference is: Reason, J. (1990) Human Error. Cambridge: University Press, Cambridge.; E.g., In operation room situations one very important barrier is in patient identification and risk stratification by applying "time out procedure". After complex procedures, failures or complications debriefing is helpful (Literature is available about improving safety by using checklists).

User: 57 [2016-10-14 11:05:22] - This is too unspecific, for example electrical supply how sure should it be, here a think we need some more examples
Roland Valori: this would be difficult because there are a lot and some will be specific to a unit. I think each unit should carry out its own risk analysis and not just refer to a list. I have expanded the note and made reference to published guidance and we may provide references here

User: 56 [2016-10-31 09:53:02] - I strongly agree Maybe even mention that protocols on antibiotic and anticoagulation that should be updated as new guidelines come out

User: 93 [2016-11-04 10:12:56] - I agree with Roland and hopefully it is important to have giudelines from ESGE. Checklists are mandatory and shoud be taken from ESGE. I do believe that we should speak a common language and to follow common european rules.

User: 66 [2016-11-06 13:35:18] - Preparing checklists is important and (must) be suggested to all units. These checklists contain both universal guideline notes and also national or institutional necessities.

User: 58 [2016-11-07 14:04:46] - At least mention the sign-in/ time-out and sign-out as a safety check

User: 101 [2016-11-10 05:32:53] - Time out is not the correct term: The better term is sign-in, Team time out, sign out

---------- End Statement ----------

4.2 We recommend endoscopy services perform a root cause analysis of all major events such as missed cancers, and unplanned admissions and unexpected deaths following endoscopic procedures

Editorial Comment:

No substantive comment apart from recommending a critical incident reporting system now mentioned in the note. However, there was strong agreement to combine 4.2 and 4.3 which has been done

Evaluative Text:

basic safety behaviour: learn from things that happen to know what to do to avoid them recurring. There is a question of what 'major' means in this context. Various publications have categorized degrees of harm but there are not equivalent publications on quality. However, no one would disagree that delayed diagnosis of cancer is a major quality parameter.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Structured and protocolized review review (root cause analysis of adverse events, including avoidable harm or avoidable death)	No review	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	8 (36.4%)	14 (63.6%)	4.6	100%

Comments:

User: 57 [2016-10-14 11:05:22] - Do we need a definition of major events or refer to MST?
Roland Valori: fair comment. I have expanded the note but we shall need further input to this

User: 68 [2016-10-14 11:05:22] - I suggest that documentation of complication rate must be accomplished by an independent medical team, preferably a surgeon, a pathologist or a cardiologist, who is not involved in the endoscopy team and everyday praxis, and these complication rates and serious adverse events must be published yearly in public on a list of a local medical journal or online on the local endoscopy society website.

Roland Valori: I have sympathy with the view of external independent validation of complications but not sure we can recommend this in the guideline. I also totally agree with you about publication of complication rates but there are all sorts of problems with this. firstly, it is beyond the scope of this guideline, secondly it is an individual nation matter. perhaps the most important concern is with definition and adjustment for case mix. also for some parameters such as death within 30 days of a PEG for example a zero death rate would indicate to me the threshold for doing a PEG is too high. so I am with you on these views but see lots of problems.

User: 59 [2016-10-14 11:05:22] - Review systematically missed cancer and unplanned admission could be a very hard job to organize. If I agree with the principle I would suggest not to include it in the recommendation , or to reduce the strength of the recommendation to a suggestion ?
Roland Valori: this has become common place in the UK so it is not that difficult to do. rather than change the recommendation I propose we leave it to the voting

User: 56 [2016-10-31 09:56:58] - I strongly agree and would leave the recommendation as is We as endoscopist should learn from our shortcomings and that is the only way to improve

User: 57 [2016-11-01 14:50:47] - I do agree that we should use the MST definitions of adverse events though I think as indicated in the statement, all unplanned admissions are serious adverse events

User: 93 [2016-11-04 11:27:18] - I think that we must not be ashamed if we have adverse events (it is part of medicine and life), a fortiori, they must be published to save other colleagues in front judges if they know that such kind of events can appen

User: 101 [2016-11-10 05:03:10] - Should we recommend to use a CIRS (critical incidence reproting system)?

---------- End Statement ----------

4.3 We recommend endoscopy services use the learning from review of adverse events to improve the service

Evaluative Text:

linked with previous one this is how the airline industry reduces the risk of planes crashing. Could be joined with previous recommendation. Question for those voting: should we join this recommendation to the previous one?

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Producing findings from structured and protocolized review review (root cause analysis of adverse events, including avoidable harm or avoidable death), implementing change. Audit cycle	No dissemination of findings, No directed changes, No audit cycle.	Changes in practice. Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (4.5%)	11 (50%)	10 (45.5%)	4.4	95.5%

Comments:

User: 59 [2016-10-14 11:05:22] - Agree to join it with previous recommendation
Roland Valori: thank you. We could join them but they are two distinct and very important processes and I would prefer to leave them separate for the moment. Shall we see what the voting comes up with. I have made a comment on the second note asking whether these two recommendations should be combined

User: 92 [2016-10-21 14:29:56] - i think we should join it with previous recommendation.

User: 92 [2016-10-21 14:31:11] - join to previous recommendation.

User: 73 [2016-10-30 07:12:15] - Agree to join it with previous recommendation

User: 94 [2016-10-30 10:44:01] - i would also link it with previous recommedation

User: 77 [2016-10-30 15:09:12] - agree to join it with previous recommendation

User: 56 [2016-10-31 09:57:52] - Yes please do join it

User: 95 [2016-11-01 04:26:01] - Agree to join it with previous recommendation

User: 74 [2016-11-01 17:05:11] - Please join the recommendation to the previous one.

User: 93 [2016-11-04 11:31:42] - Me too I agree

User: 81 [2016-11-06 12:08:17] - I agree joining them, but better to change order and leave it seperate as complication analysis is different from how to obtain better cleaning in colonoscopy as an example.

User: 60 [2016-11-06 13:13:16] - I would join it with the previous statement.

User: 66 [2016-11-06 13:42:22] - Joining with the previous one may be adequate

User: 58 [2016-11-07 14:08:22] - I agree to join it with the previous recommendation

User: 101 [2016-11-10 05:06:51] - Sorry, we should add CIRS in this statement CIRS = Critical incidence reproting systems and CRM = Crew resource management are instruments used by airlines and are widely used by anaesthetists. That are helpful instruments to learn from mistakes, adverse events and complications

---------- End Statement ----------

4.4 We recommend there be a process for capturing and reviewing all adverse events to determine whether risk reduction procedures and improvements arising from learning are effective and whether further improvements are required.

Editorial Comment:

There were some issues raised about this recommendation, particularly whether it is possible to know interventions have been effective because cause and effect is difficult to prove. The recommendation has been changed to reflect this

Evaluative Text:

basic requirement to know that what has been put in place has been successful: if you don't measure you do not know. As adverse events are so rare in endoscopy it is reasonable to review all of them to determine whether anything could have been done, with the benefit of hindsight, to prevent them.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Structured and automated process of capturing and reviewing adverse events.	No formalised adverse event monitoring or review	Changes in practice. Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	4 (18.2%)	9 (40.9%)	9 (40.9%)	4.2	81.8%

Comments:

User: 59 [2016-10-14 11:05:22] - I agree with the recommendation but would it be possible to rephrase it in a more simple English to increase the understanding of the target population? mitigation (instead of reduction) is not well known by non-English speaker
Roland Valori: I will rephrase. I have replaced mitigate with reduce

User: 57 [2016-10-14 11:05:22] - I think this is a challenging point, serious events are rare in

endoscopy a from a sample size perspective it would be difficult to assess the effect? Roland Valori: I am not sure that sample size is relevant here. It is perfectly reasonable to review all adverse events, especially as they are so rare, to determine whether anything could have been done with the benefit of hindsight to prevent them. I have amended the note

User: 52 [2016-10-14 11:05:22] - video recording/capturing
Roland Valori: I am not sure we can require video capture at this stage, certainly not of adverse events ebcause they occur so infrequently

User: 56 [2016-10-31 10:00:27] - I strongly agree Maybe even have a monthly meeting in the endoscopy unit among all involved and review what went wrong

User: 57 [2016-11-01 14:55:36] - I think this is really important. However, I am concerned about the assessment of the intervention for rare events and whether the outcome improves by chance or due to the intervention

User: 74 [2016-11-01 17:10:29] - Probably a software that facilitates registering adverse events might be useful.

User: 93 [2016-11-04 12:00:09] - I agrre with ID 56 and 57: videorecording can show the quality of the endoscopy: the problem is that it is expensive to have it

User: 60 [2016-11-06 13:15:45] - I agree, it does make sense. I am just not sure how feasible in common practice this is.

User: 81 [2016-11-06 14:29:38] - This is a difficult one, which can have multi different interpretations.

---------- End Statement ----------

4.5 We recommend that if there is insufficient resource to reduce risks, that these risks are put on a ?risk register?

Editorial Comment:

This statement did not meet the required level of agreement and it has been changed to reflect the comments.

Evaluative Text:

There are some risks that have to be accepted if there is insufficient resource to reduce them. For example a service may not be able to stock all the available devices to arrest bleeding following a polypectomy. Declaring that there is an outstanding risk (for example on a risk register - which may be called something else in another country) raises awareness that there is still a potential problem and increases the likelihood that the necessary resources will be found.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	identification of potential risks and resources available to reduce them. Identification of resource gaps where resources are needed e.g. identification of whether a service has all available devices to arrest bleeding following polypectomy.	No risk register for resources	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Allocation of resources, provision of required equipment, personnel etc.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	1 (4.5%)	7 (31.8%)	8 (36.4%)	6 (27.3%)	3.9	63.6%

Comments:

User: 68 [2016-10-14 11:05:22] - We need to define minimum standards of endoscopic facilities and accessories for every high level difficulty operative endoscopic procedure, and also those needed to treat potential complications, otherwise the procedure risk cannot be optimalized.
Roland Valori: recommendations for individual procedures is the remit of the other working groups. As a general principle however it is better to define what needs to be achieved than be prescriptive of what equipment etc. needs to be in place

User: 59 [2016-10-14 11:05:22] - We recommend suggest (?) that if there is insufficient resource to mitigate risks, that these risks are put on a ?risk register'

User: 92 [2016-10-21 14:51:55] - i think we should recommend that each organization should address its scope of services according to the available resources.

User: 56 [2016-10-31 10:09:56] - Strongly agree as this is important to know what you are lacking. The question is: Are there any publications out there to guide the endoscopy units on what they should have and what they should not have for any particular procedure ?

User: 95 [2016-11-01 04:37:03] - Maybe I have misunderstood, but I do believe that if a endoscopy unit does not have the required instruments and equipment for a procedure, then maybe such procedures should not be performmed in such a unit. Why accept a risk for a patient, and then put such a case in a register?

User: 93 [2016-11-04 11:39:29] - I do believe that if in an Endoscopy Unit there are not the best devices to perform a procedure and to treat complications, those procedures must not be done!

User: 101 [2016-11-10 05:17:25] - The term "risk register" is not clear for me. Is it a national wide register, a local register? Is it s.th. in the public domaine or an internal register to raise a risk? What is the purpose of this register? I agree with the other comments: If the necessary equipment and also competencies are not available, the procedure should not be performed in the department.

---------- End Statement ----------

Section: Appropriateness

5.1 We recommend endoscopy services have available, in written and electronic form, guidelines for all endoscopic procedures performed within the service based on regional and/or national guidelines.

Editorial Comment:

No comment.

Evaluative Text:

most jurisdictions accept that there should be criteria for performing an invasive and potentially dangerous procedure. Having them available makes it more likely they will be used

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Guidelines for all endoscopic procedures performed within the service based on regional and/or national guidelines. Written and electronic form. Clear criteria for performing invasive procedures. Regular review and updating cycle?	Guidelines not available, not reviewed and updated. No clear criteria are available	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Under or over utilisation of endoscopy services. Inappropriate use of endoscopy

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	3 (13%)	4 (17.4%)	16 (69.6%)	4.6	87%

Comments:

User: 57 [2016-10-14 11:05:22] - I think we should be careful about recommending local guidelines, I think most of them (nearly all should be national)
Roland Valori: Agreed: I have removed the word local form the recommendation

User: 56 [2016-10-14 11:05:22] - It is important that the Endoscopy nurse manager also be

aware that whoever is performing these "invasive and potentially dangerous procedures" be adequately qualified to do them. For example, an endoscopist who is going to perform an EMR on flat polyp, is he/she adequately qualified to do it? How many have they done? Is there a system in place that keeps credentialing endoscopists for these invasive procedures? Have they taken any tests to qualify them? Like DOPYs
Roland Valori: this comment is extremely important and we should consider a specific recommendation along these lines

User: 76 [2016-10-14 11:05:22] - It may be difficult to check for appropriateness at least in my Country, were most of the endoscopy units have an open access reservation system
Roland Valori: we have not asked for vetting in this recommendation but I would argue that open access should be vetted against guidance as much as from any other source

User: 68 [2016-10-14 11:05:22] - We need to centralize those high difficulty level procedures, such as ERCP or ESD, were minimal number of procedure per endoscopist yearly can be defined to keep the level of competence.
Roland Valori: Again I agree. See comment higher up. Unfortunately not an issue for the guideline but we may mention this in the general commentary

User: 57 [2016-11-01 15:03:56] - I think would should state a need for yearly revision

User: 93 [2016-11-04 11:52:50] - Again I would like to have European guidelines and to have the minimum number for each procedure /operator/year to ensure quality and safety for doctors and patients, for example how many gastroscopies, polipectomies, EMR, ESD, ERCP, EUS.... each single MD has to perform/year to ensure quality...

User: 58 [2016-11-07 14:25:54] - I agree wtih the comment about ' qualified to perform invasive procedures'. But the questions is how to define. What is an inappropriate use of endoscopy

---------- End Statement ----------

5.2 We recommend endoscopy services have policies and processes in place to assess the appropriateness of procedures against guidelines and take action when endoscopic procedures are done inappropriately.

Editorial Comment:

There were some concerns raised about requiring colleagues to comply with guidelines. But one comment explained that: "If there is a reason not to follow a specific guideline, this should be in agreement with the patient, consented and documented in patients file". No change to statement.

Evaluative Text:

there is considerable evidence that appropriateness guidelines are not followed especially for surveillance procedures. Having methods in place to check compliance with guidelines reduces risks to patients and ensures resources are used appropriately. It is noted that there are sometimes very good reasons to perform procedures outside of published guidelines. One approach to being too prescriptive is to require referrers to be, at the very least, explicit about why the patient has been referred outside guidelines. Review of referral outside guidelines should take exceptional circumstances into account. For some situations such as intervals to next surveillance procedure should only rarely fall outside guidelines.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Review of procedures against guidelines for all endoscopic procedures performed within the service based on regional and/or national guidelines. Written and electronic form. Clear criteria for performing invasive procedures. (How will the information about procedures be collected in order to assess if there done appropriately? what is the governance structure and how will action be taken when endoscopic procedures are done appropriately. Will this be action against individuals or centres?) this needs some careful thought and this recommendation may need to be split to address this.	Review against guidelines not done.	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Under or over utilisation of endoscopy services. inappropriate use of endoscopy.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (4.5%)	11 (50%)	10 (45.5%)	4.4	95.5%

Comments:

User: 57 [2016-10-14 11:05:22] - National guidelines?? Here we have a real problem since most surveillance guidelines have a poor scientific basis
Roland Valori: I have taken out the word local from the recommendation. I agree about the surveillance guidelnes but there is little we can do abut this. We are in a vulnerable position if we recommend departing from national guidance

User: 74 [2016-11-01 17:57:40] - Indeed it needs a careful thought since guidelines are generally not followed specially by other specialites.

User: 56 [2016-11-04 09:52:55] - Ok I strongly agree but no studies and the CAG Guideline does not mention this. But I strongly agree that this should be done however we are opening a can of worms here as I can see endoscopist saying: Well if you are going to do this then this should apply to everything that is done on the hospital such as indications for surgeries or admissions to the hospital etc.... Plus I can see a problem occurring as some doctors will say even though the procedure is not indicated I still feel it needs to be done as I do not feel comfortable treating this patient etc....

User: 81 [2016-11-06 14:51:40] - If there is a reason not to follow a specific guideline, this should be in agreement with the patient, consented and documented in patients file.

---------- End Statement ----------

Section: Information, consent and further care

6.1 We recommend endoscopy services have policies and procedures in place that are aligned with national and organisational requirements to ensure patients provide informed consent prior to having an endoscopic procedure

Editorial Comment:

General agreement with this statement but point made about consent starting well in advance of the procedure and this point is now made in the note. No change to statement

Evaluative Text:

basic requirements in most countries

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Informed consent procedure protocolized and documented for every patient and every procedure. Audit of consent process	No formal consent process. No audit of consent process	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (4.5%)	4 (18.2%)	17 (77.3%)	4.7	95.5%

Comments:

User: 57 [2016-11-01 15:07:39] - I think that an important point is to mail written information to the patient regarding the procedure at least a week prior to the examination to obtain a relevant informed consent

User: 74 [2016-11-01 18:07:01] - This is a very important issue. In [...] the National Society of Endoscopy has been working on it and for this purpose the Joint Committee of this Society has been elaborating several forms of Inform consent for every procedure to facilitate them to all endoscopy Units.

User: 56 [2016-11-04 09:54:50] - I think it I essential to do this and we are working towards this and now we are doing this in our hospital

User: 93 [2016-11-04 12:14:23] - In Italy we already have this from SIED (Italian Society of Digestive Endoscopy):the patient has some days before the written information and at the moment of the endoscopy, in front of the doctor he sign the informed consent

User: 101 [2016-11-10 05:25:59] - Do we have to mention that informed consent has to be given in a written format, explaining the aim of the procedure / treatment with its benefits, risks and potential alternative treatments?.

---------- End Statement ----------

6.2 We recommend endoscopy services provide patients with the information required about their procedure to enable them to provide informed consent

Editorial Comment:

Points were made about patients understanding information. Statement changed to reflect this

Evaluative Text:

a basic right for patients: what any patient would want. But different patients will want different amounts of information. The endoscopy service should, ideally, provide basic information and give patients an opportunity to ask further questions and to regularly ask patients with the amount and detail of the information is appropriate.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Provision of information in appropriate formats and audit of consent process	No provisional information, no audit of consent process	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	6 (27.3%)	16 (72.7%)	4.7	100%

Comments:

User: 57 [2016-10-14 11:05:22] - Another challenge amount and quality of information required
Roland Valori: point taken. The note has been expanded

User: 92 [2016-10-21 15:10:16] - i think we should recommend a policy for each endoscopic services that ensure patient understanding of the procedures benefits,risks and alternatives.

User: 56 [2016-11-04 10:00:07] - The note should be written in at least 3 languages. Maybe a note re: Languages.. I am not sure whether they will read it ... I also think that the most important part is that the

physician really explains the procedure and I think we all fall short in that

User: 93 [2016-11-04 12:22:27] - We have the standard information sheet; if the patient does not understand something, at the moment of the written consent, he asks to the doctor before signing

---------- End Statement ----------

6.3 We recommend endoscopy services provide patients, prior to the patient leaving the service, with the results of the procedure, the timing and mode of communication of pathology results and a plan of next steps

Editorial Comment:

General strong support for this but suggested to correct the omission of what do when things go wrong after the patient leaves the service. Statement has been chaged to reflect this

Evaluative Text:

a basic right for patients: what any patient would want

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Patient treatment plan and pre-booking services available. Correspondence copied to patients.	No provision prior to the patient leaving the service, of the results of the procedure, the timing and mode of communication of pathology results and a plan of next steps	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	1 (4.5%)	0 (0%)	7 (31.8%)	14 (63.6%)	4.5	95.5%

Comments:

User: 57 [2016-11-01 15:12:20] - This is extremely important. However, we face an important challenge regarding sedated patient not able to understand and memorize the information. What do we do with them?

User: 56 [2016-11-04 10:01:29] - Very Very important and I would also add--- in case of emergency --- Please contact etc....

User: 56 [2016-11-04 10:13:32] - Strongly agree The unit should also be able to handle emergency situations that may occur during the or after the procedure such as: Tachycardia or Bradycardia or Hypotension post endoscopy etc... Just had this problem today with a patient who was hypotensive post colonoscopy and I said to the nurse please give 1L IV NS

Bolus and the manager comes to me and tells me to send the patient to the ER --- Can you believe this?

User: 93 [2016-11-04 12:34:03] - I answer to ID 57: every sedated patient must be accompained by someone and the docto must speak whith him/her after the procedure. Of course I agree with ID 56. If a patient undergoes to polipectomy, we give to him specific written instructions

User: 66 [2016-11-06 14:15:16] - Strongly agree

User: 81 [2016-11-06 14:56:48] - I agree with ID 57. If immediately relevant , eg staging a carcinoma immediate results have to be communicated. For non-emergencies follow-up steps should be planned and clear to the patient

User: 58 [2016-11-07 14:43:17] - Again, define the sign-in, time-out and sign out, everybody feeling responsable for the procedure and patient. With the education group of ESGENA we are now establising these guidelines.

User: 101 [2016-11-10 05:36:06] - In addtion to the interview /final consultation, patients need written information before they are leaving the department, especially when they received any kind of sedation. This is part of the sign-out process.

---------- End Statement ----------

Section: Comfort, Privacy and Dignity

7.1 We recommend endoscopy services have procedures in place to assess the comfort of patients before, during and after procedures

Editorial Comment:

No comment.

Evaluative Text:

the ESGE patient representative on our first conference call told us that she was receiving many complaints from patients about pain associated with endoscopic procedures, especially colonoscopy. Knowing what patients are experiencing is the first step to improving patient comfort. Assessment of comfort should include both feedback from patients (or their carers) but also an assessment by staff, nurses as well as endoscopists.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Recording and monitoring of patient comfort including pain. Proactive provision/prophylactic provision pain relief Provision of pain relief and comfort including toilet facilities, personal hygiene facilities, privacy	No patient consultation about patient experience. No pain relief or comfort facilities offered. Pain relief offered only on demand	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (4.5%)	7 (31.8%)	14 (63.6%)	4.6	95.5%

Comments:

User: 52 [2016-10-14 11:05:22] - and feedback
Roland Valori: point emphasised in note(it is important point)

User: 56 [2016-10-14 11:05:22] - I also recommend that every patient is seen & examined by the endoscopist before they leave the endoscopy unit. This is a minimum. You have just performed an invasive procedure on a patient and the least I could do is to examine their

abdomen before they leave.
Roland Valori: I am not sure we can recommend this. Some would argue we would never get anything done. It is common practice for nurses to discharge patients in the UK and regular reviews indicate that patients are more than happy with this, providing they have the necessary information and now about next steps

User: 59 [2016-10-14 11:05:22] - I'm always choked when staff member, non involved in procedure in progress, enter the room when patient is awake, particularly when it is a lower GI exploration. I believe we have to stress that or to redefine "comfort". Roland Valori: we have dicussed this by email and I shall insert a new recommendation for privacy and dignity

User: 66 [2016-10-14 11:05:22] - This also depends on the physical status (environment) of the endoscopy suit. For example, decreasing pain may be achieved by sedation and analgesia but this can be done if your endoscopy unit has appropriate observation room(s) and anesthesiology support.
Roland Valori: point noted but we can recommend what should be in place but we cannot recommend how it should be achieved

User: 93 [2016-11-04 15:02:13] - I agree with ID 56 but, sorry, I disagree with Roland: the doctor is the unique responsable of the procedure and he has to see and, if necessary to visit the patient before disharging him: it i salso a medico-legal problem.

---------- End Statement ----------

7.2 We recommend information on comfort is reviewed and fed back to endoscopists and staff and, where appropriate, action is taken to improve patient comfort levels

Editorial Comment:

No comment.

Evaluative Text:

see 7.1. Action needs to be taken to protect patients from unnecessary pain

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Recording and monitoring of patient comfort including pain. Proactive provision/prophylactic provision pain relief Provision of pain relief and comfort including toilet facilities, personal hygiene facilities, privacy	No patient consultation about patient experience. No pain relief or comfort facilities offered. Pain relief offered only on demand	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	10 (45.5%)	12 (54.5%)	4.5	100%

Comments:

User: 57 [2016-10-14 11:05:22] - What is an acceptable comfort level? The same in UK, Norway, Lebanon?
Roland Valori: there is of course no recommended acceptable comfort level. This is not what is being asked. The recommendation is just asking for comofrt levels to be reviewed. This will show variation and this will enable questions to be asked

User: 92 [2016-10-21 15:24:30] - assess and maintain

User: 57 [2016-11-01 15:20:24] - As above I think an open process with all the members of the staff in the endoscopy unit is essential to increase the effect of the feedback

User: 56 [2016-11-04 10:13:09] - I never thought of this but I strongly agree

---------- End Statement ----------

7.3 We recommend information on comfort is reviewed and fed back to endoscopists and staff and, where appropriate, action is taken to improve patient comfort levels

Editorial Comment:

No comment.

Evaluative Text:

action is necessary to complete the audit cycle

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Recording and monitoring of patient comfort including pain. Proactive provision/prophylactic provision pain relief Provision of pain relief and comfort including toilet facilities, personal hygiene facilities, privacy. Audit of patient experience.	No patient consultation about patient experience. No pain relief or comfort facilities offered. Pain relief offered only on demand	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	9 (42.9%)	12 (57.1%)	4.6	100%

Comments:

User: 77 [2016-10-30 15:33:51] - similar to 7.2 recommendation

User: 56 [2016-11-04 10:15:13] - Very similar to previous

User: 93 [2016-11-04 12:54:42] - I agree with 56 and 77

User: 66 [2016-11-06 14:25:49] - Same with the previous one

User: 66 [2016-11-06 14:26:24] - can be merged

User: 100 [2016-11-09 09:15:54] - Sililar to 7.2

User: 101 [2016-11-10 05:41:13] - Similar to 7.2. can we combine it?

---------- End Statement ----------

7.4 We recommend that endoscopy services provide an environment and have processes in place that ensure the privacy and dignity of patients is respected and ensured.

Editorial Comment:

No comment.

Evaluative Text:

it is all too common for endoscopy teams to forget about the privacy and dignity of patients. It is not possible to be prescriptive of what privacy and dignity means: it will be different in different cultures and may be constrained by the physical nature of unit. It is advised endoscopy services use patients (and their carers) who access the service to help define what is required and then test whether this is meeting patient needs by asking patients regularly about their experience.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Recording and monitoring of patient comfort including pain. Proactive provision/prophylactic provision pain relief Provision of pain relief and comfort including toilet facilities, personal hygiene facilities, privacy. Audit of patient experience.	No patient consultation about patient experience. No pain relief or comfort facilities offered. Pain relief offered only on demand	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	4 (18.2%)	18 (81.8%)	4.8	100%

Comments:

User: 56 [2016-11-04 10:15:49] - Strongly agree

User: 60 [2016-11-06 13:23:26] - Very important.

---------- End Statement ----------

Section: Staffing

8.1 We recommend that the endoscopy service undertakes regular skill mix reviews to identify gaps

Editorial Comment:

There was some confusion about terminology so statement changed. Also comment about ESGENA having guidanec in this ares is added to the note

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Identification of qualitative and quantitative demands on endoscopy service. Scheduled and regular reviews of staffing/Skill mix Resources to recruit and train staff as demands change	No staffing reviews No change in staffing No resources available for recruitment	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Personnel retention

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	1 (4.5%)	0 (0%)	11 (50%)	10 (45.5%)	4.4	95.5%

Comments:

User: 56 [2016-10-14 11:05:22] - I agree and I think that we do not have good evidence based literature on this subject. This is something that we in [.....] are struggling with.

User: 59 [2016-10-14 11:05:22] - Is the word "mix" needed ?
Roland Valori: This is standard language in the UK. I like it because it emphasises the point that the unit requires with mix of skills

User: 57 [2016-11-01 15:23:34] - For non-native English I think the explanation is essential

User: 56 [2016-11-04 10:17:25] - I am not sure I understand this recommendation . Can you please explain: regular skill mix reviews

User: 93 [2016-11-04 13:02:06] - We should have the same standards throughout Europe

User: 56 [2016-11-05 02:31:26] - Ok now I see what u mean after I read the comment by Dr.

Valori ... Mix of skills I like that and never really thought of it

User: 56 [2016-11-05 02:43:15] - I also think that the staffing of nurses is a very important aspect of endoscopy and I am not sure whether this should be added in this Guideline but I personally think it should... I think that nurses are hired but are not trained the way it should be and are trained on the job. There are no quality parameters for nurses (I think there should be) no milestones etc... Here in [.....] young recently graduated nurse is thrown into the mix of endoscopies and "told to see one do one teach one" just like we were trained and I think these days are past us .. We should be addressing this as they impact our endoscopy unit ... (For example, how well does the nurse know when and how to close a snare to perform a Polypectomy ? Settings on the cautery machine etc...)

User: 60 [2016-11-06 13:32:30] - It should be explained, hard to understand.

User: 81 [2016-11-06 15:03:56] - This statement can be interpreted in many different ways. Staff should be balanced in training , experience, equipment, ... ?

User: 58 [2016-11-07 14:30:50] - For nurses there is also a jobprofile, look at the ESGENA site

User: 101 [2016-11-10 05:48:11] - I like to answer on ID 56: There are national competence criteria for nurses developed in many European countries. On the European level ESGENA developed a European job profile and a Core Curriculum. Skill mix cover all professions working in Endoscopy. not only phycisians and nurses, alsl technicians or secretaries, etc.

---------- End Statement ----------

8.2 We recommend that all new staff (including new endoscopists) undertake an induction and orientation programme before working in the service

Editorial Comment:

no change

Evaluative Text:

each endoscopy unit is different, often with significant differences in culture, processes and policies. To provide a safe, high quality service new recruits need to understand these differences even if they have worked in endoscopy previously

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Induction orientation programme for all new staff including endoscopists. Feedback and changes to programme.	No induction and orientation programme for new staff	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Personnel retention

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	7 (31.8%)	15 (68.2%)	4.7	100%

Comments:

User: 93 [2016-11-04 13:12:47] - absolutely agree: but how long does it take? How many days, how many procedures in the new place before becoming confident?

User: 56 [2016-11-05 02:44:06] - Please see my previous comment .....

User: 101 [2016-11-10 05:50:05] - All hospitals have such induction and orientation programmes in place. It is important to have an endoscopy specific one

---------- End Statement ----------

8.3 We recommend that the endoscopy service ensure that all staff (including the leadership team) have the necessary training and achieve the required competencies to undertake their roles.

Editorial Comment:

no change

Evaluative Text:

no explanation required: this is a basic requirement of any service within or outside healthcare. There are two key aspects to this requirement. The service needs to have instruments to assess competencies ? or at least create them. Secondly, the service needs to have staff that are able to do the training. In certain circumstances the service will not have the capability to carry out the training and if so it should be ?outsourced? elsewhere ? and the necessary resources to do this need to be identified.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Training and competency assessment for all staff (As discussed this is problematic because we do not have quantifiable measures of adequate training and competency)	No formal training or competency assessment	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Personnel retention

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	7 (31.8%)	15 (68.2%)	4.7	100%

Comments:

User: 56 [2016-11-05 02:47:05] - Strongly agree ... Please see my previous comment ... Should there be quality parameters for nurses ? (A good Research question Dr. Valori maybe outside the scope of this guideline but should we work on that.. Just an idea!)

---------- End Statement ----------

8.4 We recommend the endoscopy service recognizes and rewards exceptional contributions to the service, and

Editorial Comment:

This statement is not well understood so it has been rewritten

Evaluative Text:

recognizing and rewarding motivates staff to excel

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Monitoring and assessment of staff contribution. Reward aand recognisation ofexceptional contribution	No monitoring assessment or reward schemes.	Personnel retention

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	3 (13.6%)	6 (27.3%)	5 (22.7%)	8 (36.4%)	3.8	59.1%

Comments:

User: 56 [2016-10-14 11:05:22] - I also recommend that Endoscopists recognize the great work that these nurses and technicians are doing. Often, they are not treated well and sometimes verbally abused. There should be no room for such behavior. These nurses and technicians do not work for us physicians but rather for the hospital.

User: 57 [2016-11-01 15:27:21] - This statement is to obscure because it is difficult to define what an exceptional contribution is

User: 74 [2016-11-02 17:21:15] - I agree with previous comments it is difficult to establish or define something as an exceptional contribution, it cannot be measured. Rewarding specially young endoscopists might not be the best approach for an Endoscopy Unit to progress.

User: 93 [2016-11-04 13:16:18] - I do not understand this statement

User: 56 [2016-11-05 02:48:21] - Strongly agree .... Rewarding is a great motivator and a great incentive...

User: 60 [2016-11-06 13:36:13] - Good idea, but I have to agree with ID 74 - it is very difficult

to define it.

User: 66 [2016-11-06 14:37:37] - Rewarding may be recommended for development and improvement of the unit

User: 100 [2016-11-09 09:24:23] - What is exceptional contribution, and who should make the dicisions and amount of reward?

User: 101 [2016-11-10 05:52:43] - This needs to be explained as the previous comments show

---------- End Statement ----------

8.5 We recommend there is a process for confidential reporting and acting upon abuse of endoscopy staff from patients, other staff or endoscopists.

Editorial Comment:

Minor chanage to statement to reflect comment about process being in line with hospital policy

Evaluative Text:

unfortunately there are still reports of bullying, harassment, verbal and other forms of abuse in all health care services. It is advocated there is a zero tolerance of such behaviours and that offenders are dealt with promptly and effectively, even if this means withdrawing privileges to work in the service.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Confidential reporting of Harassment and bullying in the workplace. Structured reporting, investigation and disciplinary procedures. (usually these are institution wide rather than specific to the endoscopy service, does this need an individual recommendation other than to follow local policies in terms of discrimination or harassment and bullying and other issues related to the workplace?	No local or institutional policies on workplace harassment bullying, discrimination	Personal retention.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	8 (36.4%)	14 (63.6%)	4.6	100%

Comments:

User: 57 [2016-11-01 15:32:04] - Though I strongly agree I have some legal concerns about mentioning withdrawing privileges to work in the service.

User: 74 [2016-11-02 17:29:31] - I totally agree with zero tolerance to such inadequate behaviour from any person (patient, staff, etc). However, although a confidential report is

totally recommended, this should be established in accordance with each institutional policy.

User: 56 [2016-11-05 02:52:27] - I cannot agree more to that ... Zero Tolerance ....

User: 81 [2016-11-06 15:07:14] - The general rules from the hospital are followed here: yellow and red carts for inadequate behavior (compare football)

---------- End Statement ----------

Section: Patient inolvement

9.1 We recommend the endoscopy service gathers patient feedback on a regular basis

Editorial Comment:

Questions have been raised about frequency and objectivity and these have been referred to in the note. The statement has been changed to be more specific about timing

Evaluative Text:

patients are best placed to comment on what it is like to experience the service and if the service is to become patient centered it is essential patients are asked for their perspective. The feedback should cover all aspects of the patient experience including booking, admission, comfort, privacy, dignity and aftercare processes.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Collecting, monitoring and actioning patient feedback continuously	No review of patient feedback	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	11 (50%)	11 (50%)	4.5	100%

Comments:

User: 81 [2016-10-14 11:05:22] - General remarks on patient safety and suggestions, which might be helpful: In leadership and organization: No matter what level of quality or safety there is at the initiation of an improvement process, implementation of general management rules which very well fit as an adjunction to the recommendations are a system which could be applied to every organization throughout Europe; in this case endoscopy units. (There is a lot of literature on this subject). Suggested: E.g. applying the Deming cycle (Plan >Do>Act < Check) and thereby monitor improvement in quality over time. By Johannes Vietze - Own work, CC BY-SA 3, https://commons.wikimedia.org/w/index.php?curid=26722308 All recommendations from this article could be implemented up in an (yearly) evaluation

User: 92 [2016-10-21 16:07:33] - i think we should recommend gathering the feedback of all customers internal and external.

User: 57 [2016-11-01 15:34:46] - When you are writing regular do you mean continuously or for example one month a year?

User: 74 [2016-11-02 17:35:12] - How frequent should this feedback be gathered? Among all aspects this feedback should cover, probably the most difficult one might be the aftercare process. A survey/enquiry before the patient is discharged from the Endoscopy Unit might help.

User: 56 [2016-11-05 02:54:35] - An essential part of the unit should they unit be transparent and I think it should... Maybe we should add also that there should be policies in place that say something should be done about these suggestions

User: 60 [2016-11-06 13:43:55] - I would say continuously and evaluated at least once a year.

User: 66 [2016-11-06 14:45:44] - Isn't is too long for "Once a year"? And who will evaluate these feedbacks. A staff who is not included in the "endoscopy team" may be more objective on evaluating feedbacks. A report of the survey then must be shared with the team for improvement.

User: 58 [2016-11-07 14:36:36] - Each year by a external unti.

---------- End Statement ----------

9.2 We recommend there is a process for reviewing patient complaints and suggestions

Editorial Comment:

no change

Evaluative Text:

patient complaints and suggestions are a valuable source of patient feedback and should be taken seriously

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Collecting, monitoring and actioning patient feedback continuously	No review of patient feedback	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	12 (54.5%)	10 (45.5%)	4.5	100%

Comments:

User: 92 [2016-10-21 16:11:08] - I always concern about identifying all customers needs.

User: 56 [2016-11-05 02:55:08] - Please see my comment above

User: 66 [2016-11-06 14:47:40] - My comment about 9.1 will be similar for this also

---------- End Statement ----------

9.3 We recommend that the service acts on both formal and informal feedback from patients to improve the service and is able to demonstrate it has addressed concerns when these are raised

Editorial Comment:

statement reworded to improve the English

Evaluative Text:

gathering feedback and reviewing complaints and suggestions is a waste of time if changes to improve the service are not made

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Collecting, monitoring and actioning patient feedback continuously	No review of patient feedback	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (4.5%)	10 (45.5%)	11 (50%)	4.5	95.5%

Comments:

User: 56 [2016-11-05 02:55:41] - Please see comment above

User: 66 [2016-11-06 14:48:24] - Similar with 9.1

---------- End Statement ----------

Main included evidence for above PICOs

- Armstrong_2012_Canada LG
- Rizk_2015_asge LG
- Segnan 2010

Main excluded evidence for above PICOs

- Canadian Task
- Nice guidelines_update
- Rutter 2015
- Tinmouth 2014

Working Group: Endoscopy service Round 2

Section: Leadership and organisation

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

Evaluative Text:

There are a variety of leadership competency frameworks against which endoscopy leaders can be assessed. Accountability here refers to who the team is accountable to for governance (essentially quality and safety). In a hospital there will usually be well-defined pathways for governance but in stand-alone units it may not be so clear ? but it is important. A leadership team should create a culture of high quality and safety, and one that is patient centred.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Leadership team, with defined roles and responsibilities and accountability Is this locally, regionally or nationally?	No defined leadership team	Continued improvements in technique, quality and safety of endoscopy [(Detection, treatment, progression to advanced cancer.) This outcome may not need to be described explicitly for each performance measure, but possibly an overarching statement of the ultimate aim of high-quality endoscopy services should be included in the manuscript.]

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	8 (29.6%)	19 (70.4%)	4.7	100%

Comments:

User: 56 [2016-12-25 09:51:03] - I strongly agree with this statement. What would help are the following: 1) A leader who is interested In quality and who has that culture and is willing to spread this among his/her colleagues. 2) Hospitals have a quality departments (as mentioned in the Editorial Note), however I am not sure they fully understand what endoscopy unit quality is all about. But the point is well taken. 3) I like the part in the

Editorial Note that states: " There are a variety of leadership competency frameworks against which endoscopy leaders can be assessed". I think this is important as we want a leader that can be that is continuously assessed whether they are doing a good job or not.

User: 56 [2016-12-27 02:26:41] - Pertaining to my above comment, I also quote the Kaminski et al. article published in GUT. Please view Library.

User: 83 [2017-01-04 03:38:53] - Leadership team should be organised nationally

User: 58 [2017-01-13 13:01:45] - Totally agree, important tot organise

---------- End Statement ----------

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

Evaluative Text:

An endoscopy service should first of all determine the demand it expects and what level of service provision is required to deliver indicated by European and National regulation and guidance. Then it can define the resources it needs. There is intense pressure on endoscopic capacity in most countries and resources are constrained everywhere. It is important to maximise use of resources (and many services will be under intense pressure to do more for less) but this can put patients at risk and affect quality and patient experience. This recommendation recognizes the tension.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Strategy and monitoring/ feedback for organisation, maximisation of resources, service delivery, appropriate utilisation.	No coherent strategy for organisation, monitoring, feedback. maximisation of resources, service delivery, appropriate utilisation. Inappropriate pressure on endoscopic resource, including personnel.	Patient satisfaction, quality and safety. Personnel retention problems.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	9 (33.3%)	17 (63%)	4.6	96.3%

Comments:

User: 56 [2016-12-25 09:58:07] - I strongly agree with this statement. I can give numerous examples of resources being constrained and I am speaking about my own unit: Recovery room facility (No nurses, no cardiac or respiratory monitor, no vital sign monitoring. I can go on.... These are some examples that we could use and maybe state them for endoscopy units to focus on Dr. Valori. But I think it will be too much to come up with a list and maybe it is better to have the units identify on their own what these resources are...

User: 56 [2016-12-25 10:09:01] - I thought about it some more. I really think we should identify these resources for them that need to be accounted for. I think it is too broad of a term to say: " Then it can define the resources it needs". How will they know what resources they need? Is this mentioned in the "European and National regulation and guidance" ? We

can brainstorm and identify these resources... Suggestions please?

User: 61 [2017-01-04 08:09:02] - A crucial part of any endoscopy service is to assess the demand, and match capacity. This includes, plant, kit, and all staff across the endoscopy workforce. Calculations based on active timetables and job plans are essential together with the ability to backfill all vacant endoscopy lists. Additional factors for year on year predicted increase in demand and the impact of National Awareness campaigns will also need resourcing.

User: 93 [2017-01-09 05:48:09] - It is very important to extablish the gastroenterology workload valid for all Europe, as we did in Italy long time ago (how many endoscopies divided per typology for each endoscopist and two nurses in 6,20/7,36 hours)

User: 82 [2017-01-12 12:51:31] - I agree with the recognition of tension. I do not agree with "first determine the demands". Im my eyes this ist to far away from reality and usualy not the the way it goes. Quality stays first.

---------- End Statement ----------

Section: Facilities and equipment

2.1 We recommend that the endoscopy service carry out an assessment of the facilities and equipment required to deliver the service at least annually.

Evaluative Text:

No time interval has been stipulated but at least annually would be appropriate. An endoscopy unit cannot function without the necessary facilities and equipment

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Annual assessment of facilities and equipment required to deliver the service. Does this also build in a requirement to assess standard of equipment against new guidelines for example high-resolution endoscopes are now recommended in many guidelines?	No scheduled assessment of facilities and equipment required to deliver the service. No resources available to carry out assessment.	Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	9 (33.3%)	18 (66.7%)	4.7	100%

Comments:

User: 92 [2016-12-23 06:09:28] - I suggest the availability of a responsible expert person for maintainence of devices.

User: 56 [2016-12-26 02:59:02] - That is perfectly reasonable. Once a year is also reasonable and makes common sense, even though there are nothing to compare it to in terms of interval. I also suggest that the person reviewing this knows what he or she is doing. A endoscopy manager is not her or his job to do this. We have in our hospital engineers who come and do that and check all equipments. We have a problem with scopes going for repair and often these scopes are not being replaced by " loaner scopes". I think the industry needs to realize that this is an important issue to look at for the continued function of the unit. Maybe this is outside the scope of this guideline.

User: 66 [2017-01-08 11:23:53] - "at least annually" may be appropriate

User: 74 [2017-01-08 15:52:57] - To guarantee quality and safety in every endoscopic procedure a defined interval is required. Annual assessment of facilities and equipment should be strongly recommended,

User: 58 [2017-01-13 13:05:21] - once a year seems reasonable. A garentee for quality

---------- End Statement ----------

2.2 We recommend that the endoscopy service has a planned programme of inspection, calibration and maintenance of its clinical equipment according to the manufactures? advice and relevant national regulations

Evaluative Text:

This is a basic requirement to minimise the risk of equipment failure

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Planned programme of inspections calibration and maintenance, minimally according to manufacturer specifications. I mention minimally because it may be necessary to inspect more frequently or regularly depending on heavy usage or not, and other factors That might include tests aimed at ensuring complete disinfection.	No planned program	Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	8 (29.6%)	18 (66.7%)	4.6	96.3%

Comments:

User: 56 [2016-12-26 03:15:03] - I strongly agree with this statement and it makes common sense. However, we have to define " relevant national regulations" We have to state this in the guideline what these guidelines are. Don't we?

User: 101 [2017-01-02 17:06:40] - We cannot define "relevant national regulations" as national law and regulations might differ from country to country.

User: 61 [2017-01-04 08:11:51] - A minimum requirement would be to have annual inspection of all medical equipment (Manufacturer and / or accredited estates / medical engineers. Annual training / competency based assessments of all users is also essential.

User: 66 [2017-01-08 11:26:30] - I think we can add "annual plan" if the manufacturers'

advice is longer than one year

User: 74 [2017-01-08 15:44:01] - Agree with a planned program, however how "frequent" this inspection should be, depends on each country, manufacturers, etc.

---------- End Statement ----------

2.3 We recommend that the endoscopy service has a plan to address shortfalls, replacement and purchase of facilities and equipment

Evaluative Text:

Planning equipment replacement is a basic requirement.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Annual review of servicing, replacement or purchase of facilities and equipment. See also 2.1 above, assess standards against new guidelines and advances.	No scheduled reviews	Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	7 (25.9%)	19 (70.4%)	4.7	96.3%

Comments:

User: 56 [2016-12-26 03:19:46] - I strongly agree and again makes perfect sense. Please see above 2 comments as they also apply to this statement.

---------- End Statement ----------

2.4 We recommend that decontamination facilities, equipment and processes meet national and/or European standards

Evaluative Text:

A basic requirement. Services should follow ESGE guidance if there is no national guidance. It is suggested there be a named person responsible for overseeing compliance of decontamination.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Provision of decontamination facilities equipment and processes that meet national and/or European standards.	Failure to provide decontamination facilities.	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	2 (7.4%)	25 (92.6%)	4.9	100%

Comments:

User: 56 [2016-12-26 03:26:58] - Strongly agree with this and makes perfect sense. Again I would like to point out what this means: " meet national and/or European standards". Should we tell them what these standards are? Will this be a reference that they will go to and search for it and apply it? After all we are telling them that they should follow these standards. I could do a search on PubMed and get them for us. Maybe this has been done by the team. I did not find it in the "View Library section". Please advise....

User: 81 [2017-01-08 11:02:33] - Strongly agree; the test for an adequate decontamination is to culture endoscopes on regular basis, to prevent potential hazardous infections in patients.

User: 57 [2017-01-09 06:14:56] - I think the European standard should be a minimum and a different national standard must be superior to the European

User: 58 [2017-01-13 13:09:33] - Totally agree, important to define the national - European standards.

---------- End Statement ----------

Section: Quality

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

Evaluative Text:

Capturing and presenting performance data is essential for a unit to be able to demonstrate its endoscopists reach required standards, and to monitor improvements if they are required. The ESGE and some national bodies recommend the minimum key performance indicators that should be captured.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	No: Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	8 (29.6%)	19 (70.4%)	4.7	100%

Comments:

User: 56 [2016-12-30 03:53:06] - I strongly agree. This has been proven in many studies and I would like to quote at least one study published in GIE by Kahi et al. (Impact of a quarterly report card on colonoscopy quality measures. Gastrointestinal Endosc. 2013 Jun;77(6):925-31) I will COPY/PASTE the conclusion: " CONCLUSION: A quarterly report card was associated with improved colonoscopy quality indicators. This intervention is practical to generate and implement and may serve as a model for quality improvement programs in different patient and physician groups." I think this is very important and this should serve the basis on why we should "recommended endoscopy services to have systems in place for capturing and presenting key endoscopy performance indicators for all procedures undertaken in the service"

---------- End Statement ----------

3.2 We recommend key performance indicators are fed back to and discussed with endoscopists on a regular basis, and that corrective action for improvement, when indicated, with objectives are agreed with the individuals

Evaluative Text:

Systematic reviews indicate that when health professionals are given data on their performance they will, in most circumstances, improve. There is evidence that this is the case in endoscopy. However, improvement in response to feedback is highly variable because some may not consider it necessary to improve and others may not know how to get better: not all endoscopists will automatically get better when presented with performance data. So a discussion and a plan, with agreed objectives is necessary if they are to improve. It is expected that the endoscopist member of the leadership team will conduct this discussion. This may include further training that may have to be sourced elsewhere.The frequency of feedback and discussion depends on the metrics for the procedure and the sample size required to know whether performance is below acceptable levels. It is recommended that feedback occurs at a minimum of six month intervals, more frequently if concerns have been raised about performance from patients, endoscopy staff or other endoscopists. An open discussion of performance (all endoscopists knowing each others data) is to be recommended to foster an open and quality focussed culture.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	No: Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	5 (18.5%)	21 (77.8%)	4.7	96.3%

Comments:

User: 56 [2016-12-30 05:56:00] - Strongly Agree. Please see my comment to the previous statement.

User: 57 [2017-01-09 06:16:15] - Should we say a minimum every 6 Months?

---------- End Statement ----------

3.3 We recommend that the endoscopy service ensures that if corrective actions for improvement have been ineffective that new actions are agreed and implemented and/or that the host organisation quality and risk committee is informed of continued underperformance.

Evaluative Text:

To protect patients an endoscopy service has to check that its corrective actions have been effective and if not that something is being done about it. The way to show a corrective action has been effective is to set some measurable objectives and then ensure those objectives have been achieved within a set timescale. Clearly it is unacceptable if the objectoves are not achieved. If not then there has to be a review of why not and if the reason is beyond the control of the endoscopy team then the problem has to be escalated ?up? to someone who does have the influence and control to do something about it. For example, there may be an endoscopist who refuses to improve his/her performance, or who has unacceptably bad behaviour when in the unit which he/she refuses to, or cannot change. The endoscopy unit may not directly employ this endoscopist and the unit may have.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Audit cycle of whether the endoscopy service is: Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	No: Defining performance indicators and data Capturing performance indicators Structured reporting Automated reporting Feedback and retraining of personnel	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Endoscopist training (and sanctions? Do we want to even consider this?!)

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	1 (3.7%)	1 (3.7%)	13 (48.1%)	12 (44.4%)	4.3	92.6%

Comments:

User: 92 [2016-12-23 06:33:28] - I suggest developping prevetive actions and FMEA mode for each critical process.

User: 56 [2016-12-30 06:11:42] - I do agree with this statement with some reservation. But

what corrective action should the endoscopy unit take? The particular endoscopist may say, well how about other services in the hospital, are we following the same action for a surgeon who does not meet quality standards in surgery (if there are any)? Are we doing the same thing to an Internist who did not admit a patient with chest pain for a few days duration and now the patient has an MI with a low ejection fraction? I am not sure how practical that statement is and whether it can be enforced as the endoscopist may challenge this legally I am not so sure this can be enforced. Now what was done in the UK (and please correct me if I am wrong) was to subject endoscopy units and endoscopists that want to do a CRC screening program to an intensive exam (both written and practical for the endoscopist) and the unit has to meet certain quality standards if they want to be a screening facility. Those that do not qualify are told they cannot participate. But yet if they fail this test, they can still perform endoscopy but not CRC screening. Well what we are proposing here in this statement is that the unit should take corrective action and forbid the endoscopist to do any endoscopy. Do we really think that this will be applied? Just a thought ....

User: 81 [2017-01-08 11:14:53] - Although this is always a very difficult subject e.g. in the Netherlands there are protocols for the case of a dysfunctioning medical specialist. The Medical Society can install an independent committee to study the functioning of the person involved and can give advice to the Board of the hospital to approve the continuing of his work or deny or order an tract of improvement.

User: 82 [2017-01-12 13:14:45] - We do want to be a legislative, not an executive. Dont we?

---------- End Statement ----------

3.4 We recommend it is made clear which diagnostic and therapeutic procedures endoscopists are competent and allowed to perform in the service.

Evaluative Text:

An endoscopist performing a procedure he/she is not trained and competent to perform will put patients at risk and is therefore a major governance issue. We suggest a register is kept of who is allowed to do what in the endoscopy unit. This will empower nursing staff and other endoscopists, ideally through the leadership team, to challenge endoscopists who perform procedures they do not have permission to do. This does raise issues of who is responsible for governance such as local services, professional bodies, national health services or health insurance companies. It also raises the issue of how competence is defined. This will be the subject of future ESGE guidance. There is also the issue of how many procedures an individual should be expected to do during a given time period and what cover there should be for emergency endoscopy such as for upper GI bleeding and ERCP. These last two points are beyond the remit of this guideline

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Register of which personnel are deemed competent and adequately trained in individual endoscopy procedures. This is slightly problematic because there are no standards definitions by which a person who is doing at endoscopy is known to be adequately trained or competent.	No register of trained competent endoscopists	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Endoscopist training (and sanctions? This does raise issues of who is responsible for governance.. Local services? professional bodies, national health services? health insurance companies?

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	3 (11.1%)	0 (0%)	10 (37%)	14 (51.9%)	4.3	88.9%

Comments:

User: 92 [2016-12-23 06:37:43] - I suggest that each unit listing the privilges for each

endoscopist according to their competency and experience.

User: 56 [2016-12-30 06:24:19] - I agree with this statement and I also strongly agree if this makes any sense. While in my heart I strongly agree, is this practical? we have many hospitals and some have a low volume of endoscopy. How are you going to regulate this? An endoscopist may be doing 10 polypectomies per year. Is this an adequate number for him/her to perform? If it is not, then should we forbid them from doing polypectomies? Will the hospital defend him or her? The endoscopist may challenge this and say, how about other services? Like Surgery, ENT, Ophthalmology etc... Are they following the same standard ? They may challenge this legally. So I will only agree with this though in
my heart I strongly agree... Please let me know your thoughts....

User: 77 [2017-01-07 10:18:07] - I disagree. Listing responsibilities and areas of expertises e.x ERCP, advanced therapeutic endoscopy, based on CV and experience, and capturing adverse events will protect from incompetence. Adding written lists of strictly who performs what, will deprive motivation from endoscopists, create bounderies in innovation and will encourange nursing staff arguements with doctors in fields that are not really qualified. Besides, in practice it is difficult to specify such lists. For example i am qualified to cut a polyp of less than 2 cm and not to piece meal resection? or perform banding ligation of varicees and not banding AVMs? or perform only grade 1 in difficulty ERCP and not a cholangioscopy or a lithotrypsi?

User: 95 [2017-01-08 14:06:03] - If the endoscopist satisfies the requirements after practical and theoretical examination for each type of investigation, he/she can then carry out the work (diagnostic and / or therapeutic). However, this certification cannot be indefinite, and it is therefore necessary to have quality control. Then on the basis of this indicators we can decide on further action. As it is discussed in the preceding paragraphs.

User: 74 [2017-01-08 17:18:59] - Defining competence in each procedure is priority before deciding who is allowed to do it.

---------- End Statement ----------

Section: Safety

4.1 We recommend endoscopy services identify all potential risks to patients and staff and implement policies and procedures to mitigate them

Evaluative Text:

The best way to avoid risks is to prevent them. The best way to prevent risks is to know what they are and put in place processes to avoid them. For example having protocols for patients on anticoagulants and in room check lists (?time out?). While there will be some common risks to patients different services will have different risks. Services are referred to other guidance on safety such as antibiotic and anticoagulation guidelines.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Identification of potential risks Protocols and checklists for potential risks How wide is this does it include general safety such as safe working practices and biohazards? Could this be termed as standard operating procedure manuals produced, reviewed and kept up-to-date	No standard operating procedures	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	8 (29.6%)	18 (66.7%)	4.6	96.3%

Comments:

User: 56 [2016-12-31 01:25:23] - That makes a lot of sense. After all we want safety to our patients. Again I would like to point out that we need to say it in the guideline what these safety measures should be. Or even maybe to point the reader to a guideline they can read. For example, Anti-coagulation, Antibiotics, Cardiac & Respiratory monitoring, recovery room nurse, time outs in the unit etc... I really think we should tell them what these are and these points that should be followed. Would like to hear your comments about this...

User: 58 [2017-01-13 13:21:45] - A sign in, a time-out and a sign -out is neccessary for the safety of the patient

---------- End Statement ----------

4.2 We recommend endoscopy services perform a root cause analysis of all major events such as missed cancers, and unplanned admissions and unexpected deaths following endoscopic procedures and use the learning from the analysis to improve the service

Evaluative Text:

Basic safety behaviour: learn from things that happen to know what to do to avoid them recurring. There is a question of what 'major' means in this context. Various publications have categorized degrees of harm but there are not equivalent publications on quality. However, no one would disagree that delayed diagnosis of cancer is a major quality parameter.Services might consider using a CIRS: critical incidence reporting system. The process of learning from adverse events is how the airline industry reduces the risk of planes crashing.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Structured and protocolized review review (root cause analysis of adverse events, including avoidable harm or avoidable death)	No review	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	3 (11.1%)	5 (18.5%)	19 (70.4%)	4.6	88.9%

Comments:

User: 59 [2016-12-21 14:45:55] - Identifying missed cancer may difficult to implement at a local/hospital level particularly in country with a broad medical facilities offer

User: 56 [2016-12-31 01:35:02] - It makes perfect sense to do this and I think the airline industry is a perfect example. I will give a perfect example, for instance, " Interval CRC". I think that if you identify an Interval CRC and the incidence, you can always go back and look at the DVD and see why it was missed. By reviewing the DVD, you can see whether this was due to poor endoscopic withdrawal technique vs. incomplete Polypectomy vs. hiding behind a fold vs. flat lesion vs. alternate biology from the adenoma - carcinoma sequence vs. Serrated adenoma. I strongly agree with this statement.

User: 74 [2017-01-08 17:26:20] - The concept of major events in an Endoscopy Unit seems too "wide", I certainly agree there must be a classification for Degree of harm in the context of Endoscopy Services.

User: 58 [2017-01-13 13:23:33] - a CRM system can help

---------- End Statement ----------

4.4 We recommend there be a process for capturing and reviewing all adverse events to determine whether further improvements are required.

Evaluative Text:

Basic requirement to know that what has been put in place has been successful: if you don't measure you do not know. As adverse events are so rare in endoscopy it is reasonable to review all of them to determine whether anything could have been done, with the benefit of hindsight, to prevent them.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Structured and automated process of capturing and reviewing adverse events.	No formalised adverse event monitoring or review	Changes in practice. Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	10 (37%)	16 (59.3%)	4.6	96.3%

Comments:

User: 92 [2016-12-24 12:03:59] - I suggest that each unit providing measures which ensure the continous improvement culture.

User: 56 [2016-12-31 01:39:54] - Strongly agree. And I would like to refer to my previous comment above. Again it makes perfect sense to learn from your mistakes. This also builds honesty and humbleness in a GI unit.

User: 77 [2017-01-07 11:35:27] - very difficult to follow up the patients for capturing adverse events! Altough crusial, what type of process for capturing adverse events we suggest? Telephone patients after a month like a survey? or reviewing the data bases systematically for checking for re admissions or repeat endoscopies?

User: 93 [2017-01-09 06:11:08] - very important but very difficult to achieve

---------- End Statement ----------

4.5 We recommend that if there is insufficient resource to reduce the risks of a procedure to recommended levels, the service should review whether it should, on the balance of benefits and risks, continue to perform that procedure

Evaluative Text:

The first step if there is insufficient resource to reduce a risk is to decide whether the sevrice should do that procedure. Wlitmately it may be decided that there are some risks that have to be accepted if there is insufficient resource to reduce them. For example a service may not be able to stock all the available devices to arrest bleeding following a polypectomy. Declaring that there is an outstanding risk (for example on a risk register - which may be called something else in another country) raises awareness that there is still a potential problem and increases the likelihood that the necessary resources will be found.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	identification of potential risks and resources available to reduce them. Identification of resource gaps where resources are needed e.g. identification of whether a service has all available devices to arrest bleeding following polypectomy.	No risk register for resources	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Allocation of resources, provision of required equipment, personnel etc.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	15 (55.6%)	11 (40.7%)	4.4	96.3%

Comments:

User: 59 [2016-12-21 14:48:18] - typing error : Wlitmately=Ultimately

User: 56 [2016-12-31 01:55:15] - That's fine and I strongly agree. But why should that service do a colonoscopy in the first place if they cannot arrest a PP bleeding? Personally, I don't believe that there should be centers for just diagnostic colonoscopy. I fully understand that for flat polyps or Large polyps or Laterally spreading polyps that these patients should probably be referred out to specialty tertiary centers where there is expertise in removing

these lesions , and I believe that in the UK they are working towards something to that effect. But I believe that any endoscopist should be able to remove polyps between 1.5 cm - 2 cm in size and should have all available equipment to arrest this bleeding. I used PP bleeding as an example, but I could go on and talk about perforation etc... Would like to hear your comments...

User: 77 [2017-01-07 11:47:39] - I agree with ID 56 comment. It is the leader's of the unit responsibility and to provide the basic accessories to provide a safe endoscopy. "Insufficient source" is very general and subjective term. For example do all units have to have Oveso clips (full thickness clips),or haemospray powder to stop the bleeding ?

---------- End Statement ----------

Section: Appropriateness

5.1 We recommend endoscopy services have available, in written and electronic form, guidelines for all endoscopic procedures performed within the service based on regional and/or national guidelines.

Evaluative Text:

Most jurisdictions accept that there should be criteria for performing an invasive and potentially dangerous procedure. Having them available makes it more likely they will be used.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Guidelines for all endoscopic procedures performed within the service based on regional and/or national guidelines. Written and electronic form. Clear criteria for performing invasive procedures. Regular review and updating cycle?	Guidelines not available, not reviewed and updated. No clear criteria are available	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Under or over utilisation of endoscopy services. Inappropriate use of endoscopy

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	6 (22.2%)	20 (74.1%)	4.7	96.3%

Comments:

User: 56 [2017-01-02 04:44:55] - I strongly agree. I guess that answers my question to a lot of my above concerns on what those guidelines are. But should we tell them what guidelines are important? For example, the guidelines in an endoscopy unit should include: one on antibiotic prophylaxis, one on management of anti - coagulation , one on colon polyp surveillance etc... I think we should tell them what these are! We should let them choose ESGE vs. ASGE vs. CAG vs. Other. Would like to hear your comments about this.

---------- End Statement ----------

5.2 We recommend endoscopy services have policies and processes in place to assess the appropriateness of procedures against guidelines and take action when endoscopic procedures are done inappropriately.

Evaluative Text:

There is considerable evidence that appropriateness guidelines are not followed especially for surveillance procedures. Having methods in place to check compliance with guidelines reduces risks to patients and ensures resources are used appropriately. It is noted that there are sometimes very good reasons to perform procedures outside of published guidelines. One approach to being too prescriptive is to require referrers to be, at the very least, explicit about why the patient has been referred outside guidelines. Review of referral outside guidelines should take exceptional circumstances into account. For some situations such as intervals to next surveillance procedure should only rarely fall outside guidelines. whatever the reason not to follow a specific guideline, this should be in agreement with the patient, consented and documented in patients file.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Review of procedures against guidelines for all endoscopic procedures performed within the service based on regional and/or national guidelines. Written and electronic form. Clear criteria for performing invasive procedures. (How will the information about procedures be collected in order to assess if there done appropriately? what is the governance structure and how will action be taken when endoscopic procedures are done appropriately. Will this be action against individuals or centres?) this needs some careful thought and this recommendation may need to be split to address this.	Review against guidelines not done.	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Under or over utilisation of endoscopy services. inappropriate use of endoscopy.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	1 (3.7%)	4 (14.8%)	9 (33.3%)	13 (48.1%)	4.3	81.5%

Comments:

User: 59 [2016-12-21 14:53:29] - I certainly agree with the principle go the recommandation but review of all procedures to identify those against guidelines is practically impossible to implement (except if you dedicated someone almost with at least a half time for this job...)

User: 56 [2017-01-02 04:59:05] - Is that a word we can use: prescriptive? I strongly agree. But is it practical? In my heart I would like this to happen. I also like what was mentioned in the Editorial above, is that if you are going to deviate from the guideline, then this should be discussed with the patient and documented on why it is being deviated. I also think that should there be too many instances of deviation from guidelines, then this should be addressed. I like this statement, however, deep down in my heart I an skeptical whetehr it will be implemented. We have a junior staff member in our division and already in his first 2 years he has surpassed all the senior staff members in the number of endoscopies he does. Talk around the unit and the hospital is that a lot of these procedures are not indicated. How are you going to monitor this? How do you do a check on this? He may say if you do this to me, then I want this done on the whole division. This has created some problems among the members od the division and ha split the GI division. It has gone so bad that he decided to review his last 1000 endoscopies and write a paper about his endoscopic and pathologic findings to justify his procedures. Is that right? Would like to hear your comments.

User: 101 [2017-01-02 17:30:51] - It is not realistic to review all procedures against guidelines. It is realistic and essential to review adverse events and complications, but review all routine procedures is very time consuming.

User: 77 [2017-01-07 11:56:22] - We talk about the indication of a procedure which is a priority quality indicator. I think we should talk about all the quality indicators in endoscopy. QI should be periodically reviewed in continuous quality improvement programs. Findings of deficient performance can be used to educate endoscopists and/or provide opportunities for additional training and mentorship. Additional monitoring can be undertaken to document improvement in performance.

User: 74 [2017-01-08 17:34:56] - Questions raised in the interventions are very important. When endoscopic procedures are inappropriately done, who will determine the action to take? Will it be against who? The endoscopist? the nurse? the division/group?

User: 93 [2017-01-09 06:18:29] - I agree but it is difficult to do

---------- End Statement ----------

Section: Information, consent and further care

6.1 We recommend endoscopy services have policies and procedures in place that are aligned with national and organisational requirements to ensure patients provide informed consent prior to having an endoscopic procedure

Evaluative Text:

This is a basic requirement in most countries. Good quality consent starts well in advance of the procedure

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Informed consent procedure protocolized and documented for every patient and every procedure. Audit of consent process	No formal consent process. No audit of consent process	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	6 (22.2%)	21 (77.8%)	4.8	100%

Comments:

User: 56 [2017-01-02 07:51:40] - I strongly agree with this procedure. I also think that as the Editorial mentions above that this should be discussed with the patient in the clinic. However, this is not easy to do when you have an open endoscopy unit and patients just come in straight for their procedure. We just started the informed consent process in our hospital 3 months ago, and it is not ideal. The consent is usually signed by the physician after the procedure, I am sure that the risks are not well discussed beforehand etc.... It was interesting to learn from our UEGW meeting that in Sweden informed consent is not obtained or even discussed. I believe that this maybe a more honest way of doing it (or rather not doing it) instead of getting an informed consent and not actually discussing the risks and procedure. Again, it is always a fine line. I am not sure what the answer is about informed consent. I mean do we tell patients that they may die from this procedure? I know that I don't do that. I am open for discussion about this subject and maybe this is not the right forum to do it ... However having said all this I strongly agree with the statement.

User: 58 [2017-01-13 13:32:11] - For the interventions procedures you have to tell the patient

the risk of the procedures and alternatives

---------- End Statement ----------

6.2 We recommend endoscopy services provide patients with information about their procedure that is sufficiently understandable to them to enable them to provide informed consent

Evaluative Text:

A basic right for patients: what any patient would want. But different patients will want different amounts of information. The endoscopy service should, ideally, provide basic information and give patients an opportunity to ask further questions and to regularly ask patients with the amount and detail of the information is appropriate.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Provision of information in appropriate formats and audit of consent process	No provisional information, no audit of consent process	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	6 (22.2%)	21 (77.8%)	4.8	100%

Comments:

User: 56 [2017-01-02 07:59:06] - I strongly agree. But this is the ideal situation. Is it practical? Are units doing it ? I also think that this should be sent to the patient in advance or to be given to them when they arrive to the clinic and give them ample time to read it at home so that they can ask questions. Does anyone put in the informed consent the risk of death? I am not sure I agree or whetehr I understand it fully with the statement mentioned in the Editorial: " But different patients will want different amounts of information". Shouldn't we give the same consent to everyone ?

---------- End Statement ----------

6.3 We recommend endoscopy services provide patients prior to leaving the service with the results of the procedure, the timing and mode of communication of pathology results, a plan of next steps and an explanation of what delayed complications can occur and what to do about them.

Evaluative Text:

A basic right for patients: what any patient would want.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Patient treatment plan and pre-booking services available. Correspondence copied to patients.	No provision prior to the patient leaving the service, of the results of the procedure, the timing and mode of communication of pathology results and a plan of next steps	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	3 (11.1%)	23 (85.2%)	4.8	96.3%

Comments:

User: 56 [2017-01-02 08:04:13] - Strongly agree. Again that is a basic right. It is also important to stress should any of the following happen post - procedure: Abdominal pain, fever, vomiting etc... to contact immediately this number .... They should know specifically who to call etc....

User: 93 [2017-01-09 06:22:46] - I agrre also with 56

---------- End Statement ----------

Section: Comfort, Privacy and Dignity

7.1 We recommend endoscopy services have procedures in place to assess the comfort of patients before, during and after procedures

Evaluative Text:

The ESGE patient representative on our first conference call told us that she was receiving many complaints from patients about pain associated with endoscopic procedures, especially colonoscopy. Knowing what patients are experiencing is the first step to improving patient comfort. Assessment of comfort should include both feedback from patients (or their carers) but also an assessment by staff, nurses as well as endoscopists.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Recording and monitoring of patient comfort including pain. Proactive provision/prophylactic provision pain relief Provision of pain relief and comfort including toilet facilities, personal hygiene facilities, privacy	No patient consultation about patient experience. No pain relief or comfort facilities offered. Pain relief offered only on demand	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	15 (55.6%)	12 (44.4%)	4.4	100%

Comments:

User: 92 [2016-12-24 12:12:49] - This will open the door for us to recommend the availaibility of anaesthesioligist in each endoscopic procedures

User: 56 [2017-01-03 01:29:00] - In the Editor's note there is a spelling error: " carers" I think you meant caretakers" I strongly agree. I think the comfort of patients is very important and should they need another procedure in the future for surveillance or for whatever we need to make sure that this experience at the unit is optimal. Not only that, I also think that sine we need to increase the recruitment of patients for CRC screening, it is of utmost importance that we make this experience optimal. I used CRC screening as an example but this can apply for anything else in endoscopy. Safety is also very important and I am not sure if I should address this in this statement or not. I am not sure I agree to "have an anesthesiologist in

each endoscopic procedure" as my colleague suggested above. I think 95% of endoscopies can be done with IV Conscious sedation. A few patients will need Propofol sedation. Our challenge is to identify risk factors that will prompt you to suggest Propofol (i.e. Use of Psych meds, Anxious personality, problems with IV sedation + Endoscopy in the past etc...)

User: 66 [2017-01-08 11:58:26] - My comment was as follows in the first round, and I will repeat it again "This also depends on the physical status (environment) of the endoscopy suit. For example, decreasing pain may be achieved by sedation and analgesia but this can be done if your endoscopy unit has appropriate observation room(s) and anesthesiology support. "

User: 93 [2017-01-09 06:27:40] - I agree with 66,56 and 92

---------- End Statement ----------

7.2 We recommend information on comfort is reviewed and fed back to endoscopists and staff and, where appropriate, action is taken to improve patient comfort levels

Evaluative Text:

See 7.1. Action needs to be taken to protect patients from unnecessary pain

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Recording and monitoring of patient comfort including pain. Proactive provision/prophylactic provision pain relief Provision of pain relief and comfort including toilet facilities, personal hygiene facilities, privacy	No patient consultation about patient experience. No pain relief or comfort facilities offered. Pain relief offered only on demand	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	12 (44.4%)	14 (51.9%)	4.5	96.3%

Comments:

User: 56 [2017-01-03 01:39:23] - I strongly agree. It is interesting that in the Editorial note: " Action needs to be taken to protect patients from unnecessary pain". The perception of pain is very subjective. I utilize propofol maybe 5-10% of my endoscopies and it is interesting how I view pain and how the anesthesiologist view pain. I will give an example, on withdrawal of the colonoscope I often see the anesthesiologist give more propofol as soon as the patient moves an inch. I am often at odds with them and telling them that there is no need to do that as I am coming out and I can tolerate some movements. I try to tell them that I really need propofol should I encounter a difficult Sigmoid/Descending junction and once I am past that there is no need for more Propofol. So I think there should be better communication between us and the Anesthesiologist.

User: 81 [2017-01-08 13:41:29] - The downside of this recommendation is that if it is translated in giving more analgesics instead of trying to find out what the underlying problem is: eq the technique or experience of the endoscopist. Giving more analgesics instead of analyzing the condition can camouflage underlying and unforeseen complications.

User: 57 [2017-01-09 06:21:49] - Like above, maybe an advice regarding the scehdule of the

feedback is needed? At least every 6 Months

---------- End Statement ----------

7.3 We recommend information on comfort is reviewed and fed back to endoscopists and staff and, where appropriate, action is taken to improve patient comfort levels

Evaluative Text:

Action is necessary to complete the audit cycle.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Recording and monitoring of patient comfort including pain. Proactive provision/prophylactic provision pain relief Provision of pain relief and comfort including toilet facilities, personal hygiene facilities, privacy. Audit of patient experience.	No patient consultation about patient experience. No pain relief or comfort facilities offered. Pain relief offered only on demand	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	12 (44.4%)	15 (55.6%)	4.6	100%

Comments:

User: 56 [2017-01-03 01:51:28] - I strongly agree. I think that is the only way to improve is to know what you are doing wrong.

User: 77 [2017-01-07 12:04:03] - 7.2 and 7.3 statements are same. Do we need both?

---------- End Statement ----------

7.4 We recommend that endoscopy services provide an environment and have processes in place that ensure the privacy and dignity of patients is respected and ensured.

Evaluative Text:

It is all too common for endoscopy teams to forget about the privacy and dignity of patients. It is not possible to be prescriptive of what privacy and dignity means: it will be different in different cultures and may be constrained by the physical nature of unit. It is advised endoscopy services use patients (and their carers) who access the service to help define what is required and then test whether this is meeting patient needs by asking patients regularly about their experience.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Recording and monitoring of patient comfort including pain. Proactive provision/prophylactic provision pain relief Provision of pain relief and comfort including toilet facilities, personal hygiene facilities, privacy. Audit of patient experience.	No patient consultation about patient experience. No pain relief or comfort facilities offered. Pain relief offered only on demand	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	0 (0%)	8 (29.6%)	19 (70.4%)	4.7	100%

Comments:

User: 59 [2016-12-21 15:00:15] - Many thanks Roland to have included this recommandation that I told you about in the beginning of our process

User: 56 [2017-01-03 01:56:24] - I strongly agree. Recovery room areas are potential places where privacy is an issue. We often discuss the results and only a curtain is separating patients. During the endoscopy, colleagues and nurses often discuss the findings while the patient is fully aware of what is going on. We need to be cautious of this and take action. We all need to put ourselves in the patient's place.

---------- End Statement ----------

Section: Staffing

8.1 We recommend that the endoscopy service undertakes regular reviews of staff in relation to activity to identify gaps, and to improve the match of skills of staff to the work undertaken

Evaluative Text:

The qualitative and quantitative demands on an endoscopy service change with time. This means that the type and number of staff required to deliver the service is also likely to change. Regular review of the staffing of a service is essential if it is going to manage the demands put upon it. ESGENA has developed a European job profile and a Core Curriculum for nurses working in endoscopy. Skill mix cover all professions working in Endoscopy. not only physicians and nurses, also technicians and administrative staff.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Identification of qualitative and quantitative demands on endoscopy service. Scheduled and regular reviews of staffing/Skill mix Resources to recruit and train staff as demands change	No staffing reviews No change in staffing No resources available for recruitment	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Personnel retention

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	9 (33.3%)	17 (63%)	4.6	96.3%

Comments:

User: 56 [2017-01-03 10:12:11] - Spelling mistake : Endoscopy. not (There should be a comma not a period) I strongly agree. I am not familiar with the ESGENA European job profile and the Core Curriculum for nurses working in endoscopy, but I will search for it and send all of you the reference. This is crucial. The problem and it boils down to money is to see how much is the new administration of the hospital willing to pay for new staff. I am finding it hard to even get a recovery room nurse to take care of my patients and this is considered to be one of the top 3 hospitals in the country. I find that our nurses are getting burnt out and we are having a problem keeping our staff. They complain that there are too many scopes being done and no one is helping etc.... Pay is low etc... We try to speak to the administration of the hospital and they don't want to pay for overtime.

I mean this is not right... How are you going to keep staff like that?

User: 61 [2017-01-04 08:19:37] - Skill mix based on competency based training is essential for a cost effective service. The use of non-registered practitioners can add value to the service and improve recruitment and retention. The keyword is competency.

User: 58 [2017-01-13 13:42:38] - You can find the ESGENA job profile and core curriculum at het ESGENA website

---------- End Statement ----------

8.2 We recommend that all new staff (including new endoscopists) undertake an induction and orientation programme before working in the service

Evaluative Text:

Each endoscopy unit is different, often with significant differences in culture, processes and policies. To provide a safe, high quality service new recruits need to understand these differences even if they have worked in endoscopy previously.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Induction orientation programme for all new staff including endoscopists. Feedback and changes to programme.	No induction and orientation programme for new staff	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Personnel retention

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	2 (7.4%)	7 (25.9%)	18 (66.7%)	4.6	92.6%

Comments:

User: 56 [2017-01-03 10:16:46] - That makes sense. I am not sure how much I remember of my orientation initially but I think it is helpful to know the differences that may or may not exist. I think it is a fair statement to put. I strongly agree.

User: 77 [2017-01-07 12:07:33] - what is the duration of an induction and irientation program? Who's responsibility is to provide it?

---------- End Statement ----------

8.3 We recommend that the endoscopy service ensure that all staff (including the leadership team) have the necessary training and achieve the required competencies to undertake their roles.

Evaluative Text:

No explanation required: this is a basic requirement of any service within or outside healthcare. There are two key aspects to this requirement. The service needs to have instruments to assess competencies ? or at least create them. Secondly, the service needs to have staff that are able to do the training. In certain circumstances the service will not have the capability to carry out the training and if so it should be ?outsourced? elsewhere ? and the necessary resources to do this need to be identified.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Training and competency assessment for all staff (As discussed this is problematic because we do not have quantifiable measures of adequate training and competency)	No formal training or competency assessment	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety. Personnel retention

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.8%)	5 (19.2%)	20 (76.9%)	4.7	96.2%

Comments:

User: 59 [2016-12-21 15:08:59] - Again I completely agree with recommandation, I'm perplex on realizability in current economic context

User: 56 [2017-01-03 10:24:59] - I cannot agree more. This is very essential. In most units, it is see one--- do one--- teach one. Shouldn't we tell them what these " instruments to assess competencies " are? I mean we are the guideline after all. Shouldn't we tell them what the staff should assess? I mean look at the Colonoscopy Core Curriculum published in GASTROINTESTINAL ENDOSCOPY Volume 76, No. 3 : 2012. It specifically tells you what we should test the GI fellow for and what we should be looking for. It is guiding us. I think we should tell them where at least to look. Would like to hear your comments about this...

User: 56 [2017-01-03 11:00:43] - I quoted the wrong article in GIE but the article is also very

helpful. I meant to quote this article: ASGE’s assessment of competency in endoscopy evaluation tools for colonoscopy and EGD: GASTROINTESTINAL ENDOSCOPY Volume 79, No. 1 : 2014

User: 77 [2017-01-07 12:24:24] - We should also emphasize that nurses should possess the education and training appropriate for the tasks assigned. All nurses and technicians working in the endoscopy unit must receive taskspecific training based upon their responsibilities. My desire is the support of specialisation in endoscopy nurses. I would like to encourange qualified endoscopy nurses in anesthesia, in ERCP, in ESD etc. Furthermore, please add a coment on the nesecity for spirit of cooperation and mutual respect between the endoscopists and the endoscopy assistants and staff which is required for the successful performance of their role

---------- End Statement ----------

8.4 We recommend the endoscopy service has methods in place to motivate staff to improve the service

Evaluative Text:

Ultimately it is not possible to deliver a high quality service if staff are not motivated to do so. Identifying good quality care and giving staff recognition of their contribution will motivate them. For example publicly recognising when patients compliment individual members of staff. Or perhaps rewarding staff who make suggestions of how to improve the service when their idea is taken up. Recognizing and rewarding motivates staff to excel.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Monitoring and assessment of staff contribution. Reward aand recognisation ofexceptional contribution	No monitoring assessment or reward schemes.	Personnel retention

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	1 (3.7%)	2 (7.4%)	9 (33.3%)	15 (55.6%)	4.4	88.9%

Comments:

User: 56 [2017-01-03 10:33:20] - I like this. Never thought of it actually. Money always helps. But you know what also helps the most, is the way we treat our nurses. A gentle way of talking to them, asking their opinion about certain endoscopic findings, involving them in Polyp detection, treating them like colleagues --- goes a long way. I think we all should be aware of this and there is no place for bad behavior with the staff coming form physicians. There should be a mechanism where nurses and technicians can vent their complaints about abuse by physicians without being afraid that they will loose their job. Maybe we should add that as a separate statement Dr. Valori or just add it to the above?

User: 93 [2017-01-09 06:36:40] - I agree but we have to work about it

---------- End Statement ----------

8.5 We recommend there is a process for confidential reporting and acting upon abuse of endoscopy staff from patients, other staff or endoscopists in line with institutional policies.

Evaluative Text:

Unfortunately there are still reports of bullying, harassment, verbal and other forms of abuse in all health care services. It is advocated there is a zero tolerance of such behaviours and that offenders are dealt with promptly and effectively, even if this means withdrawing privileges to work in the service.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Confidential reporting of Harassment and bullying in the workplace. Structured reporting, investigation and disciplinary procedures. (usually these are institution wide rather than specific to the endoscopy service, does this need an individual recommendation other than to follow local policies in terms of discrimination or harassment and bullying and other issues related to the workplace?	No local or institutional policies on workplace harassment bullying, discrimination	Personal retention.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	6 (22.2%)	20 (74.1%)	4.7	96.3%

Comments:

User: 97 [2017-01-02 06:11:40] - I strongly agree with this.

User: 56 [2017-01-03 10:36:52] - Well there it is. You just read my thoughts. Thank you for this very important statement. I strongly agree.

---------- End Statement ----------

Section: Patient inolvement

9.1 We recommend the endoscopy service gathers patient feedback at least annually

Evaluative Text:

patients are best placed to comment on what it is like to experience the service and if the service is to become patient centered it is essential patients are asked for their perspective. The feedback should cover all aspects of the patient experience including booking, admission, comfort, privacy, dignity and aftercare processes. Surveys need to be frequent enough to truly reflect the service and ideally their objectivity might be improved if they are gathered and reviewed by a body that has no stake in the service.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Collecting, monitoring and actioning patient feedback continuously	No review of patient feedback	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	2 (7.4%)	7 (25.9%)	18 (66.7%)	4.6	92.6%

Comments:

User: 59 [2016-12-21 15:07:46] - even if annually should be ideal I would suggest to write regularly

User: 56 [2017-01-03 10:42:29] - I fully agree. I think this is a very important way to improve. I am not sure of annually or semi-annually but the point is well taken. An outside agency is key to this but again this costs money.

User: 58 [2017-01-13 13:46:43] - I am also not sure about annually, every two year

---------- End Statement ----------

9.2 We recommend there is a process for reviewing patient complaints and suggestions

Evaluative Text:

Patient complaints and suggestions are a valuable source of patient feedback and should be taken seriously.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Collecting, monitoring and actioning patient feedback continuously	No review of patient feedback	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.8%)	8 (30.8%)	17 (65.4%)	4.6	96.2%

Comments:

User: 56 [2017-01-03 10:44:47] - I strongly agree. My comments as above.

User: 93 [2017-01-09 06:52:56] - I agree but difficult to organize, as above

User: 58 [2017-01-13 13:49:05] - I agree, every organisation needs a way to find to collect complains of the patientand discuss it with teh persons to improve your unit/organisation.

---------- End Statement ----------

9.3 We recommend that the service acts on both formal and informal feedback from patients to improve the service and to demonstrate it has addressed concerns when these are raised

Evaluative Text:

Gathering feedback and reviewing complaints and suggestions is a waste of time if changes to improve the service are not made.

Population	Interventions	Comparator	Outcome
Endoscopy service providers	Collecting, monitoring and actioning patient feedback continuously	No review of patient feedback	Patient and personal safety. Continued improvements in technique, quality and safety of endoscopy. Patient satisfaction, quality and safety.

Vote 1	Vote 2	Vote 3	Vote 4	Vote 5	AVG	Agree%
0 (0%)	0 (0%)	1 (3.7%)	11 (40.7%)	15 (55.6%)	4.5	96.3%

Comments:

User: 56 [2017-01-03 10:47:08] - Strongly agree.

User: 77 [2017-01-07 12:43:02] - Altough i agree, all statements number 7 and number 9 are repeat and analyse patient satisfaction and feedback issues. Do you think we need so many statements for that? Should we reuce them to 3?

User: 93 [2017-01-09 06:54:24] - I agree with 77

---------- End Statement ----------

Main included evidence for above PICOs

- Armstrong_2012_Canada LG
- Rizk_2015_asge LG
- Segnan 2010

Main excluded evidence for above PICOs

- Canadian Task
- Nice guidelines_update
- Rutter 2015
- Tinmouth 2014