Value In Care - optimising surveillance COLonoscopy (VIC-COL)

Training guide for audit and feedback on guideline concordance in surveillance colonoscopy

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Quick Start Guide

This quick start guide provides an overview on the five key steps to determine surveillance colonoscopy interval guideline concordance.

1. **Identify eligible cases**
The first step is to identify cases eligible for the audit. Only cases where the final recommendation made by the endoscopist is for 'surveillance colonoscopy' are eligible. It is unlikely that you will audit every single case so you may need to determine a suitable sampling strategy.

2. **Collect relevant clinical information**
The NHMRC-endorsed Cancer Council Australia Guidelines for Surveillance Colonoscopy specify the information required to make a guideline-based surveillance interval decision. The information required will differ depending on the indication for conducting surveillance, most commonly they are due to polypectomy findings, family history, or specific diseases. Refer to the detailed sections of the Audit Training Guide for further details. Required information can typically be obtained from the colonoscopy report, histopathology report, pre-admission clinic notes, and pre/post-procedure correspondence with the GP. The clinical information required to make the guideline-based surveillance interval decision should be collected together with the interval assigned by the endoscopist.

3. **Determine guideline-based surveillance interval**
Using the information collected in the previous step, the recommended interval from the NHMRC-endorsed Cancer Council Australia Guidelines for Surveillance Colonoscopy. Application of the guideline is supported through use of Polyp.app, which can be used to calculate the guideline-based interval. The guideline-based interval calculation should be documented for review purposes, such as through taking a screenshot of the Polyp.app page.

4. **Conduct concordance comparison**
This step involved comparing the guideline-based interval determined in the previous step with the interval actually recommended by the endoscopist. Any documented reasons for deviation from the guidelines, such as difficult procedure or patient anxiety should be noted.

5. **Report and discuss findings**
After assessing guideline concordance, the final step is to compile the audit findings into reports summarising guideline concordance for hospitals and individual endoscopists. A plan should be made for how the findings can be discussed, such as at a regular quality meeting.

Accompanying this audit guide as separate attachments are the following working documents:

1) A spreadsheet for documenting guideline concordance (MS Excel)
2) A generic hospital feedback template (MS Word)
3) A generic endoscopist feedback template (MS Word)

4) Quick Reference Guide for Cancer Council Guidelines for Surveillance Colonoscopy (PDF)

Background

This document has been developed to assist and support clinicians conducting colonoscopy case audits for surveillance colonoscopies at hospitals committed to ongoing monitoring of guideline concordance. Audits of current episode colonoscopy cases are conducted to determine their adherence to the NHMRC-endorsed Cancer Council Australia Guidelines for Surveillance Colonoscopy and hereon in are referred to as 'The Guidelines'.

This guide elaborates on the process involved in each of the five key steps. It details information relating to the determination of the timing of surveillance colonoscopy; the source and location of audit information; familiarisation with the paper-based audit form; abbreviations; glossary of terms; a suggested workshop presentation and relevant references.

1. Identify eligible cases

Identifying cases eligible for the audit should be undertaken as a first step. Only cases where the endoscopist's final recommendation is for 'surveillance colonoscopy' are eligible.

Figure 1 is a flow chart illustrating the sequence and definition of a surveillance colonoscopy. The current episode colonoscopy represented in blue is the episode which is to be audited.

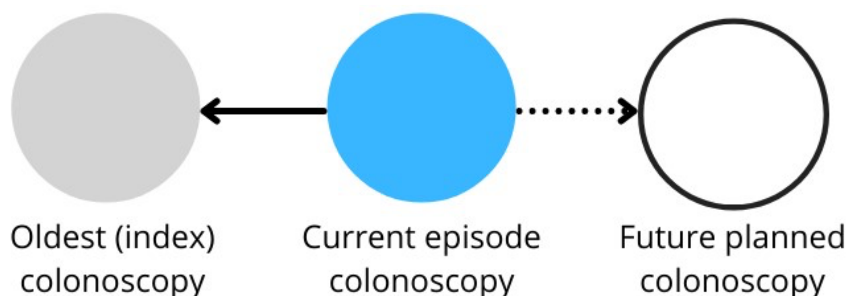


Figure 1. Flow chart illustrating the sequence and definition of surveillance colonoscopies

Each hospital may have a different database to identify colonoscopy cases undertaken. For example, some hospitals may have a booking spreadsheet of all colonoscopy cases, or some may be able to immediately identify surveillance colonoscopy cases through their Electronic Medical Records (EMR) systems. Your hospital may not have a booking list, or similar, specifically for surveillance colonoscopy and therefore, all colonoscopy cases will need to be checked to identify if they are for surveillance or other reasons.

Sampling strategy

Since auditing every surveillance colonoscopy case may not be feasible, you'll need to determine an appropriate sampling strategy. This may include systematic or convenience sampling or a combination of both depending on the resources available at your disposal. For example, supplementing the systematic sampling with convenience sampling to include additional cases from high and low risk groups.

Case identification

Identifying a surveillance colonoscopy case begins with the auditor (usually a clinician) consulting their database or the EMR system where recent colonoscopy cases are located. For audit purposes, cases are usually selected within a designated timeframe, for example per month or per quarter.

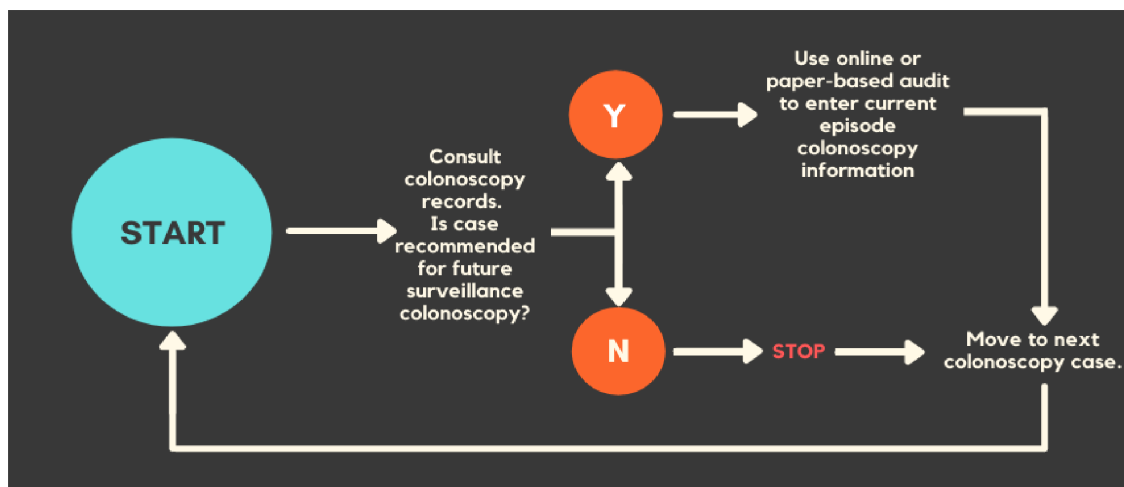
In order to ***determine if the current episode colonoscopy is a surveillance colonoscopy*** certain criteria/information should be identified. The colonoscopy is likely a surveillance procedure if the patient has a history of:

a Polyps
b Family history of colorectal cancer
c Patient was recommended for future surveillance colonoscopy

Reviewing the patient's relevant medical history helps identify those who fall into this category as the findings from previous colonoscopies directly influence the need for surveillance.

Figure 2 illustrates the process when determining if/when a current episode colonoscopy case is a surveillance colonoscopy.

Figure 2 Identification of surveillance colonoscopy cases



Surveillance of post CRC resection

Surveillance colonoscopies exclude those cases that are post colorectal cancer resection for bowel cancer as this follows a different guideline

https://cancer.org.au/clinical-guidelines/bowel-cancer/colorectal-cancer

2. Collect relevant clinical information

The NHMRC-endorsed Cancer Council Australia Guidelines for Surveillance Colonoscopy specify the information required to make a guideline-based surveillance interval decision. The
information required will differ depending on the indication for conducting surveillance, most commonly due to polypectomy findings, family history, or specific diseases. Required information can typically be obtained from the colonoscopy report, histopathology report, pre-admission clinic notes, and pre/post-procedure correspondence with the GP as outlined below in the relevant resources. The clinical information required to make the guideline-based surveillance interval decision should be collected together with the interval assigned by the endoscopist.

Relevant sources of information include:

a. **Electronic medical records (EMR)** for patient demographics such as age, gender, and family history of colorectal cancer, preadmission clinical notes and medical history.
b. **Colonoscopy reports** for details of past colonoscopies, including findings, polyp characteristics including size of the polyp, and endoscopists surveillance interval recommendations
c. **Histopathology** reports which include biopsies taken during colonoscopies, specifying the type of polyps, high-grade dysplasia, and villosity.
d. **Colonoscopy databases** such as ENDObase, Direct Access to Gastrointestinal Endoscopic Procedures, ERS and Provation Medical GI provide information on previous colonoscopies conducted at your hospital
e. **GP referral/letters** pre/post-procedure correspondence with the GP may be useful if previous colonoscopies were conducted elsewhere outside your hospital.

Table 1 shows each category of surveillance colonoscopy and the different types of documentation providing relevant information.

To ensure the audit is of the highest quality, every effort should be made to obtain all documentation (e.g. histology report, colonoscopy report, and relevant medical history) from the current episode and the oldest (index) colonoscopy, if relevant. Also, check multiple sources of evidence for confirmation of details (e.g. check colonoscopy report and histology for confirmation of number/dysplasia and villosity of polyps).

The colonoscopy report and clinical notes might also be reviewed to capture reasons impacting interval decision such as quality of bowel preparation, difficulty of the procedure, level of patient anxiety and provider discretion. Detailed sources and location of audit information can be found in Appendix 1.

NB If the information for the oldest (index) colonoscopy is not available, the current episode colonoscopy should be treated as the first.

Table 1 Audit feature and possible location of information

Conventional adenoma and/or CSSP	
Feature	**Location of information**
Number	• Colonoscopy report; histopathology report
Size	• Colonoscopy report
Adenoma	• Colonoscopy report; histopathology report
High grade dysplasia and/or villosity	• Colonoscopy report; histopathology report
Clinically significant serrated polyp	• Colonoscopy report; histopathology report
Dysplasia	• Colonoscopy report; histopathology report
Traditional serrated adenoma/s	• Colonoscopy report; histopathology report

Large sessile or laterally spreading adenoma	
Feature	**Location of information**
En-bloc or piecemeal excision	• Colonoscopy report

Colorectal cancer resection	
Feature	**Location of information**
Resection of a sporadic cancer	• Colonoscopy report
Presence of advanced adenoma/s	• Colonoscopy report
Advanced adenoma information	• Colonoscopy report; histopathology report

Inflammatory Bowel Disease	
Feature	**Location of information**
Primary sclerosing cholangitis	• Clinic notes, GP referral
Ongoing chronic active inflammation	• Clinic notes, GP referral, colonoscopy report

Prior colorectal dysplasia	• Colonoscopy report, histopathology report
Evidence of intestinal damage with colonic stricture	• Colonoscopy report
Pseudo polyps or foreshortened tubular colon	• Colonoscopy report; clinic notes
Family history of CRC at age <=50 years	• Clinic notes, GP referral
Quiescent disease	• Clinic notes; colonoscopy report
No high-risk features. 'High-risk findings' refers to advanced adenoma) size >=10mm, high-grade dysplasia [HGD], villosity or >= conventional adenomas	• Colonoscopy report, histopathology report
Inactive disease on consecutive surveillance colonoscopies	• Clinic notes; colonoscopy report

Family history of colorectal cancer	
Feature	**Location of information**
First degree relative diagnosed with colorectal cancer	• Clinic notes; GP referral
Age of first degree relative when diagnosed	• Clinic notes; GP referral
Second degree relative diagnosed with colorectal cancer	• Clinic notes; GP referral
Age of second degree relative when diagnosed	• Clinic notes; GP referral

High risk familial syndrome	
Feature	**Location of information**
Gastrointestinal symptoms	• Clinic notes; GP referral
Polyp/adenoma detected	• Colonoscopy report
Biallelic mutation carrier	• Clinic notes; GP referral; genetic referral
Age	• Patient notes
Serrated polyposis syndrome	• Clinic notes; GP referral; genetic referral

An abbreviations list and glossary of terms has been provided in Appendices 2 and 3.

Audit form

Clinical information can be recorded on the project specific paper-based audit form (Appendix 4). The information collected here will be used to determine the appropriateness of the timeline applied to the future planned colonoscopy. Progress through this paper-based audit form by entering current episode colonoscopy case information for each colonoscopy identified as a surveillance procedure.

The clinical information required to make the guideline-based surveillance interval decision should be collected together with the interval assigned by the endoscopist, which is usually obtained from the colonoscopy report or clinical notes.

3. Determine guideline-based surveillance interval

Using the clinical information collected in the previous step, the recommended interval from the NHMRC-endorsed Cancer Council Australia Guidelines for Surveillance Colonoscopy can then be determined. Application of the guideline is supported through use of Polyp.app, and can be used to calculate the guideline-based interval. The guideline-based interval calculation should be documented for review and quality assurance purposes. For example, using a screenshot of the Polyp.app page, similar to the cases outlined below.

Polyp App

Polyp.app. may be used to determine concordance for cases when they follow the polyp pathway, family history or patients with familial syndromes. Examples of surveillance intervals across these three categories are shown below.

Case 1: Two convention adenomas, <10mm in size, with no high-grade dysplasia where the results of the index case are unknown.

Surveillance

Colonoscopy Surveillance Calculator

Fill in the findings of the two **most recent** colonoscopies to determine the appropriate surveillance interval. Please note if there are other indications for colonoscopy such as family history or a polyposis syndrome, recommended surveillance intervals may differ from those shown below (see tools for family risk calculation and syndromes).

Second Colonoscopy

Conventional adenomas - 2 +

Were any of these >= 10mm?

Did any adenoma have high grade dysplasia or villiosity?

Clinically significant sessile serrated lesions - 0 +

Surveillance interval **10 years**

Guideline

This tool is based on the guidelines released by the Cancer Council Australia Clinical Guidelines Network. All tables displayed are from the short form guideline published by the same group.[1] All calculations should be checked prior to clinical use.

Case 2: Patient with a family hx of 1 x first degree relative diagnosed with colorectal cancer BEFORE 50 years, and 1 x second degree relative diagnosed BEFORE age 50.

Polyp.app

Family

Family risk calculator

Please note the below tool has been revised to reflect the updated 2023 NHMRC guideline. Significant changes have been made to the guideline, please read the recommendations closely.
I highly recommend reading the guideline summary which can be found here

TOTAL first degree relatives diagnosed with colorectal cancer	- 1 +
↳ Were any of these diagnosed BEFORE age 50?	On
↳ Were any of these diagnosed BETWEEN age 50 and 60?	Off
TOTAL second degree relatives diagnosed with colorectal cancer	- 1 +
↳ Were any of these diagnosed BEFORE age 50	On

Recommendations
Risk category is **2**

- Colonoscopy should be offered every five years starting at 10 years younger than the earliest age of diagnosis of colorectal cancer in a first-degree relative or age 50, whichever is earlier, to age 74.

- CT colonography may be offered if clinically indicated.
- Low-dose (100 mg) aspirin daily should be considered from age 45 to 70.

Approximate 10 year colorectal cancer risk at age 50 for this category is 4%.

Notes on use
This tool only applies to asymptomatic patients without a confirmed hereditary cancer syndrome.
A first-degree relative is a person's parent, full sibling or child.
A second-degree relative is someone who shares 25% of a person's genes. It includes uncles, aunts, nephews, nieces, grandparents, grandchildren, half-siblings, and double cousins.

All content and tools adapted from Cancer Council Australia Clinical practice guidelines for surveillance colonoscopy[1].

Case 3: Familial syndromes – Lynch syndrome

Polyp.app

Syndromes

Lynch syndrome

Surveillance Strategy

- Colonoscopy every 1-2 years - annual is preferred
- Commence at age 25 (or 5 years younger than youngest affected family member if < 30)
- Consider 2nd yearly gastroscopy from age 30 years in
    - families with gastric cancer
    - those at high ethnic risk - e.g. Chinese, Korean, Chilean and Japanese.

NHMRC-endorsed Cancer Council Australia Guidelines

NHMRC-endorsed Cancer Council Australia Guidelines for Surveillance Colonoscopy may be used as an adjunct to polyp app to determine concordance for other cases where further clarification is needed with regard to complex family histories, familial syndromes or specific diseases. In addition, accompanying this audit guide is the Cancer Council Australia Surveillance Colonoscopy Guidelines Quick Reference Guide for determining surveillance interval after polypectomy.

Special considerations when determining surveillance intervals

1. **Patients aged over 75 years**

Surveillance colonoscopy in those age ≥75 years should be based on age and comorbidity as assessed by the reproducible and validated Charlson score. Charlson score is useful to assess life expectancy and could be implemented to stratify benefits of surveillance colonoscopy those age ≥75 years. When determining recommended interval guidelines for patients Aged 75-80 and Aged 80+ consideration should be given to the Charlson Score (Table 2).

It is recommended to stop routine colonoscopy surveillance in patients aged 75 or older with a Charlson score of 4 or higher. Routine colonoscopy surveillance is not recommended for patients aged over 80 years.

Table 2 Charlson score for colonoscopy benefit

Table 18 . Charlson score for colonoscopy benefit

Age	Medical conditions	
75–79 years (3 points)	**May** have *one* of these conditions only (1 point each): Mild liver disease Diabetes without end-organ damage Cerebrovascular disease Ulcer disease Connective tissue disease Chronic pulmonary disease Dementia Peripheral vascular disease Congestive heart failure Myocardial infarction	**May not** have *any* of these medical conditions (≥1 point each): Moderate/severe liver disease Diabetes with end-organ damage Hemiplegia Moderate or severe renal disease AIDS Metastatic or non-metastatic solid organ or haematopoietic malignancy
80 years (4 points)	May not have any of the above medical conditions	

2. **Surveillance intervals following removal of polyps greater than 20mm in size**

Polyps greater than 20 mm in size are considered advanced adenomas and high-risk lesions. A 1-year follow-up colonoscopy is usually recommended for patients who have undergone enbloc excision of a polyp. The recommended surveillance interval should be approximately 6 months in patients who have undergone piecemeal excision. Further details on surveillance intervals following removal of polyps >20mm can be found here (page 286) https://www.cancer.org.au/assets/pdf/guidelines-colorectal-cancer-colonoscopy-surveillance

4. Conduct concordance comparison

This step involves comparing the guideline-based interval determined in the previous step with the interval actually recommended by the endoscopist. Any documented reasons for deviation from the guidelines, such as difficult procedure or patient anxiety should be noted. The comparison of the guideline-based interval with endoscopists recommendations determines concordance.

Figure 3 provides an example of the Excel file input fields of guideline-based intervals, endoscopist recommendations and concordance. Ensure there is a unique identifier for each endoscopist (column C) and enter this into the spreadsheet. This will enable individual endoscopist reports to be compiled in the following step. Complete information entry for each of the other fields and move to the next case. Complete data entry for the designated audit period chosen at your hospital. As seen in column K, the endoscopist interval decision can be assessed against the guidelines as:

1. **Concordant**
2. **Early**
3. **Late,** or
4. **No surveillance recommended**

Figure 3 Excel template for determining guideline concordance

	A	B	C	D	F	G	H	I	J	K	L
1	UR number	Date of current colonoscopy	Endoscopist Number	Follow-Up requested	Index case Reported Yes/no	Polyp App/Guideline Recommendation	Clinician check after review of colonoscopy report/histology report/ GP letter/additional notes (Column J)	FINAL GUIDELINE RECOMMENDATIONS	Notes for individual endoscopist reports	Endoscopist Recommendation	Concordance
2		18/03/2024	1	Surveillance	no	10 years	10 years	**10 years**		10 years	Concordant
3		25/03/2024	1	Surveillance	no	3 years	3 years	**3 years**		3 years	Concordant
4		23/04/2024	1	Surveillance	no	5 years	5 years	**5 years**		10 years	Late
5		23/04/2024	1	Surveillance	no	3 years	3 years	**3 years**		3 years	Concordant

NB Accompanying this audit guide is an Excel File template complete with dummy data to provide guidance on documenting guideline concordance.

5. Report and disseminate findings

After assessing guideline concordance, the final step is to compile the audit findings into comprehensive feedback reports summarising guideline concordance for hospitals and individual endoscopists. As part of the feedback on guideline concordant surveillance colonoscopy intervals, clearly state the percentage of colonoscopies that were concordant, **early, late, and no surveillance recommended** in accordance with the guidelines.

Hospital feedback reports

Providing hospital summary feedback reports on guideline concordance can drive quality improvement activities in clinical settings. By highlighting areas where guideline concordance is suboptimal, the hospital leadership team in collaboration with clinicians can develop and implement strategies to improve performance, where appropriate. Continuous monitoring with feedback ensures the impact of initiatives is observable and more likely to be sustained over time. Figure 4 provides an example of a feedback report summarising guideline concordance for surveillance colonoscopy at a hospital. See Appendix 5 for templates for first and subsequent feedback reports.

Figure 4 Template feedback report of guideline concordance for hospitals

[INSERT HEALTH SERVICE DETAILS IN HERE]

Audit of surveillance colonoscopy intervals
[INSERT AUDIT PERIOD e.g., 1 January 2024 to 31 March 2024]

[Date]

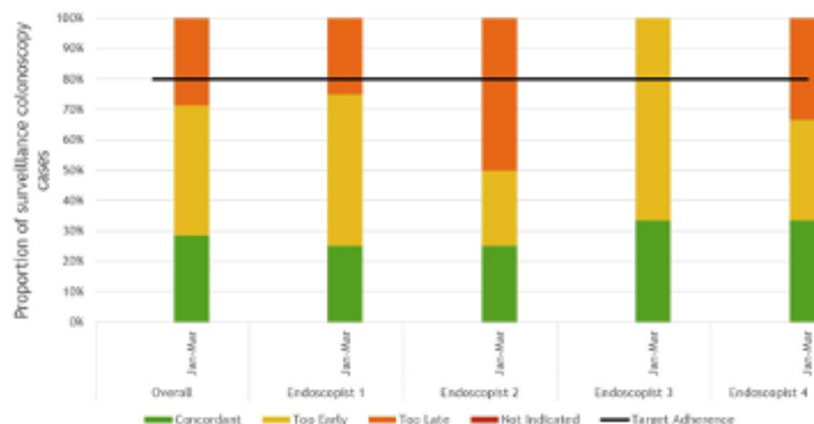
This report summarises concordance with the NHMRC-endorsed Cancer Council Surveillance Colonoscopy Guidelines[1,2] of surveillance interval recommendations made by endoscopists at [Health Service] and audited for the period [INSERT AUDIT PERIOD e.g., 1 January 2024 to 31 March 2024].

200 cases of colonoscopy were reviewed. **144** cases were excluded (not surveillance colonoscopy). **56** were recommended for future surveillance colonoscopy, had complete data to determine concordance and are included in this report.

The audit found, overall, 29% of patients were recommended a surveillance interval consistent with the guidelines for the current period

[FOLLOWING EACH AUDIT PERIOD, THE NUMBER OF CASES ABOVE SHOULD BE UPDATED TO RELFECT THE LATEST INFORMATION]

The figure below summarises overall guideline concordance for all endoscopists at [HEALTH SERVICE] for the current period [INSERT DATES e.g., 1 January 2024 to 31 March 2024]



Reports containing individualised feedback on guideline concordance of surveillance interval recommendations will be provided to individual endoscopists. Best practice resources to support quality improvement are available at https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Colonoscopy_surveillance.

Providing feedback on guideline concordance for surveillance interval recommendations to endoscopists is important as it promotes adherence to best practices, thereby enhancing the quality of care. This targeted approach helps reduce unnecessary procedures, optimises resource utilisation, and ultimately decreases waiting lists and the burden on patients. Access to best practice resources, such as those available on the Cancer Council Australia's Guidelines and Polyp app (https://www.polyp.app), supports continuous quality improvement and ensures that surveillance practices are up-to-date and evidence-based.

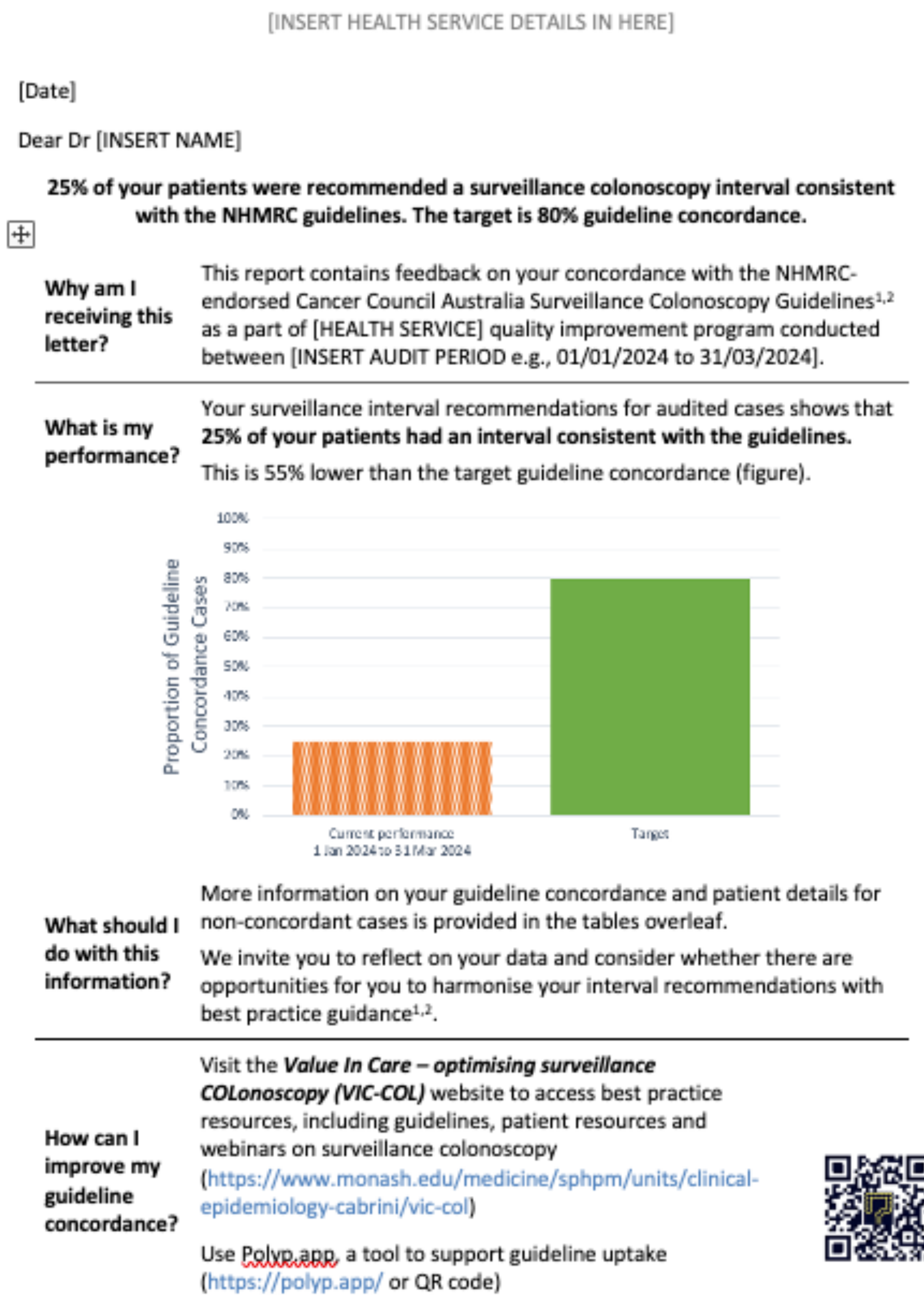
References

[1] Cancer Council Australia (2018). Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Clinical practice guidelines for surveillance colonoscopy. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/surveillance-colonoscopy
[2] Cancer Council Australia (2023). Cancer Council Australia Colorectal Cancer Guidelines Working Party. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/colorectal-cancer

Individual endoscopist feedback reports

Providing individual endoscopist feedback reports on guideline concordance allow each endoscopist to see how their practice compares to benchmarks, as well as their performance in previous reporting periods. Feedback reports enable endoscopists to consider whether there are opportunities to harmonise their surveillance colonoscopy interval recommendations in line with best practice guidance. Figure 5 provides an example of how to compile an individual endoscopist report. See Appendix 6 for templates for first and subsequent feedback reports.

Figure 5 Template feedback report for individual endoscopists



[INSERT HEALTH SERVICE DETAILS IN HERE]

[Date]

Dear Dr [INSERT NAME]

25% of your patients were recommended a surveillance colonoscopy interval consistent with the NHMRC guidelines. The target is 80% guideline concordance.

Why am I receiving this letter?	This report contains feedback on your concordance with the NHMRC-endorsed Cancer Council Australia Surveillance Colonoscopy Guidelines[1,2] as a part of [HEALTH SERVICE] quality improvement program conducted between [INSERT AUDIT PERIOD e.g., 01/01/2024 to 31/03/2024].
What is my performance?	Your surveillance interval recommendations for audited cases shows that **25% of your patients had an interval consistent with the guidelines.** This is 55% lower than the target guideline concordance (figure).
What should I do with this information?	More information on your guideline concordance and patient details for non-concordant cases is provided in the tables overleaf. We invite you to reflect on your data and consider whether there are opportunities for you to harmonise your interval recommendations with best practice guidance[1,2].
How can I improve my guideline concordance?	Visit the ***Value In Care – optimising surveillance COLonoscopy (VIC-COL)*** website to access best practice resources, including guidelines, patient resources and webinars on surveillance colonoscopy (https://www.monash.edu/medicine/sphpm/units/clinical-epidemiology-cabrini/vic-col) Use Polyp.app, a tool to support guideline uptake (https://polyp.app/ or QR code)

Figure 5 Template feedback report for individual endoscopists (cont.)

	Consider the details of your non-concordant cases (Table 2) and whether guideline-recommended intervals may be appropriate for these and other future like cases Take the opportunity to educate your patients about the benefits, harms and best practice guidance for surveillance colonoscopy
How will I benefit from this?	Time spent reviewing this feedback and exploring improvement opportunities will contribute towards your annual **AHPRA Continuing Professional Development (CPD) requirement**.

We hope you have found this information useful. If you have any questions or suggestions on how we can improve this feedback, please contact:

[INSERT REPRESENTATIVES OF THE HOSPITAL QUALITY IMPROVEMENT OR AUDIT TEAM HERE]

References

[1] Cancer Council Australia (2018). Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Clinical practice guidelines for surveillance colonoscopy. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/surveillance-colonoscopy

[2] Cancer Council Australia (2023). Cancer Council Australia Colorectal Cancer Guidelines Working Party. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/colorectal-cancer

Table 1. Timing of your surveillance interval recommendations for this period [INSERT DATES FOR AUDIT PERIOD] **compared to the NHMRC guidelines.** [ADDITIONAL COLUMNS AND RESULTS MAY BE ADDED TO TABLE 1 WHEN NEW AUDIT DATA BECOME AVAILABLE]

Timing of your interval recommendations compared to the guidelines	**CURRENT PERIOD [e.g., 1 Jan 2024 to 31 Mar 2024] % (n)**
Concordant	25% (4)
Early	50% (8)
Late	25% (4)
No surveillance recommended	0% (0)

Figure 5 Template feedback report for individual endoscopists (cont.)

Table 2. Individual patient data for the current period

Highlighted in **bold** are cases where there is a discrepancy between your recommendation and the guidelines. Please note that only you receive this data.

Patient URN	Procedure date	Your recommendation	Guideline recommendation
[insert URN HERE e.g., 324567]	**18/01/2024**	**5 years**	**10 years**
[]	23/01/2024	3 years	3 years
[]	**23/01/2024**	**3 years**	**≤1 year**
[]	**23/01/2024**	**3 years**	**5 years**
[]	**30/01/2024**	**3 years**	**5 years**
[]	30/01/2024	3 years	3 years
[]	**06/02/2024**	**3 years**	**≤1 year**
[]	06/02/2024	5 years	5 years
[]	**20/02/2024**	**5 years**	**10 years**
[]	05/03/2024	3 years	3 years
[]	**05/03/2024**	**5 years**	**10 years**
[]	**19/03/2024**	**5 years**	**3 years**
[]	**19/03/2024**	**3 years**	**5 years**
[]	**28/03/2024**	**5 years**	**3 years**
[]	**28/03/2024**	**3 years**	**5 years**
[]	**28/03/2024**	**5 years**	**10 years**

Details of non-concordant cases:

Patient URN:	[INSERT URN HERE]
Current colonoscopy findings	
Type of polyp:	**Conventional adenoma removed**
Number of polyps:	**1-2**
Size of polyps:	**<10mm**
High grade dysplasia or villosity:	**No**
Is this index colonoscopy:	**No**
Index colonoscopy findings	
Type of polyp:	**The patient had no clinically significant findings**
Endoscopist recommendation:	5 years
Guideline recommendation:	10 years
Notes:	

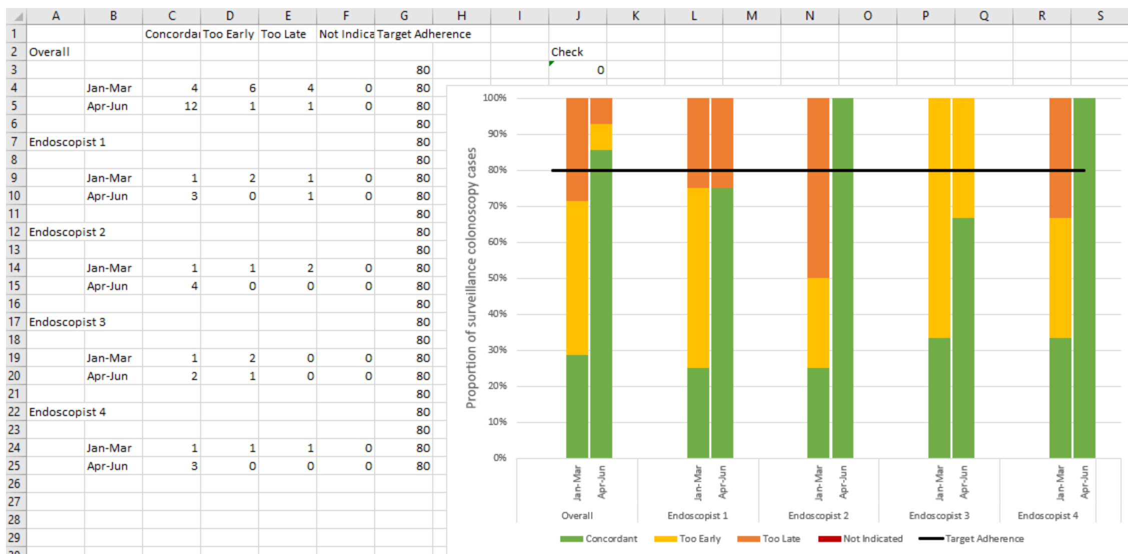
Presentation of graphs for feedback reports

Feedback reports include presentation of graphs to assist with interpretation of data. The following section provides a brief guide to graph production for hospital and individual reports.

Graph presentation for hospital-level feedback report

As described in Step 4, data from the audit form has been inputted into the excel template (Figure 3).

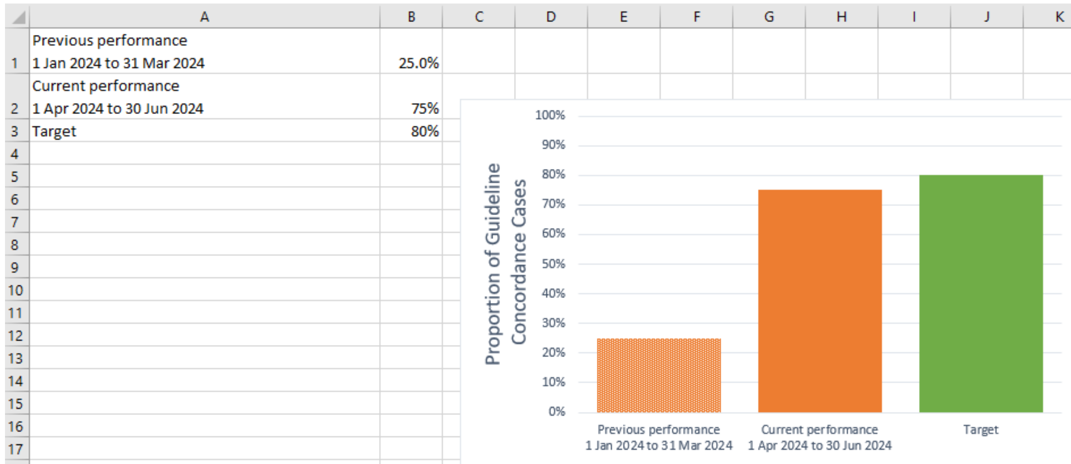
- Using the data from Figure 3, create a new excel page or file with the columns "Concordant", "Early", "Late", "Not indicated" and "Target adherence".
- List each of the endoscopists and audit periods in the rows below and insert the corresponding data from Figure 3.
- To create the graph, go to the 'Insert' tab and choose a cluster column graph type. Select the data you want to use from the table. Click 'Insert' to add your graph. Label and format each axis. Copy and paste graph from excel into the hospital summary report as shown in Figure 4.



	A	B	C	D	E	F	G	J
1			Concordai	Too Early	Too Late	Not Indica	Target Adherence	
2	Overall							Check
3							80	0
4		Jan-Mar	4	6	4	0	80	
5		Apr-Jun	12	1	1	0	80	
6							80	
7	Endoscopist 1						80	
8							80	
9		Jan-Mar	1	2	1	0	80	
10		Apr-Jun	3	0	1	0	80	
11							80	
12	Endoscopist 2						80	
13							80	
14		Jan-Mar	1	1	2	0	80	
15		Apr-Jun	4	0	0	0	80	
16							80	
17	Endoscopist 3						80	
18							80	
19		Jan-Mar	1	2	0	0	80	
20		Apr-Jun	2	1	0	0	80	
21							80	
22	Endoscopist 4						80	
23							80	
24		Jan-Mar	1	1	1	0	80	
25		Apr-Jun	3	0	0	0	80	

Graph presentation for individual endoscopists feedback reports

- Using the data from Figure 3, create a new excel page or file with the rows marked "Previous performance", "Current performance" and "Target".
- List the audit periods you have chosen under each row heading and insert the corresponding data from Figure 3.
- To create the graph, go to the 'Insert' tab and choose a cluster column graph type. Select the data you want to use from the table. Click 'Insert' to add your graph. Label and format each axis. Copy and paste graph from excel into the endoscopist report as shown in Figure 5.



NB Accompanying this audit guide is are hospital and individual report templates to provide guidance on reporting guideline concordance. If time and resources are limited there is the option of compiling the report without the graphs.

A plan should be made for how the findings can be discussed, such as at a regular quality assurance meetings or staff meetings. Accompanying this audit guide is a PowerPoint presentation template for a suggested workshop presentation for your hospital.

Appendix 1 Audit questions, detailed sources and location of audit information

Audit question	Example of information source and location
What is the follow-up recommendation for this current episode colonoscopy? ○ Surgery or procedure ◉ Surveillance colonoscopy ○ Not surveillance colonoscopy but iFOBT ○ No surveillance recommended ○ No follow-up documented ○ Follow-up in rooms/via phone/IBD Clinic ○ Follow-up with GP ○ Other [ ]	Colonoscopy report **COLONOSCOPY REPORT** Dear Dr [redacted] **PATIENT:** [redacted] **DOB:** [redacted] **DATE:** [redacted] **MBS:** 32222, 32229 **INDICATION:** Faecal incontinence. Previous prostatectomy **ANAESTHETIST:** [redacted] **FINDINGS** **Anal Canal / Rectum:** Grade 1 Internal Haemorrhoids. **Colon:** Left sided diverticular disease. 3 small polyps removed cold from the caecum and ascending colon. The ascending polyp was not retrieved. The colonic mucosa was normal. Random biopsies taken. **Terminal ileum:** Normal. **Total Time:** 10 minutes **Preparation: Average** **Withdrawal:** 7 minutes **SUMMARY** Three polyps resected and 2 retrieved. Await histology. Repeat colonoscopy in 5 years if health permits. Suggest addition of fibre to diet and consider referral to pelvic floor physiotherapist. With kind regards,

	Dear Dr PATIENT DATE OF BIRTH : ADDRESS TELEPHONE NO. : Many thanks for referring for colonoscopy for investigation of his faecal incontinence which occurs in the context of a previous prostatectomy. He has occasional episodes every few months of incontinence. He has also had previous urinary incontinence following his prostatectomy and some sort of sphincter was inserted, which helped with this. Colonoscopy today revealed grade I internal haemorrhoids as well as left-sided diverticular disease. Three small polyps were removed from the caecum and ascending colon and hence a repeat colonoscopy is recommended in five years if his health permits. There was no clear cause of incontinence today and I wonder if it relates to his previous operations. He is already having Metamucil three spoonfuls per day, so that box is already ticked; however, I would recommend consideration of referral to a pelvic floor physiotherapist who may help him with his tone issues. Many thanks again for the referral. With warmest regards, Dictated and checked by
What was the date of the current episode colonoscopy? (dd/mm/yyyy)	<u>Colonoscopy report</u> Under "Date Procedure"

	Colonoscopy Referring Doctor: Patient No. DOB: Endoscopist: Anaesthetist: Date Procedure: 2016 Copy: **Indications:** Past history of Rectal cancer. ***Findings:*** *Anus:* Normal. No anal or perianal disease was seen. *Colon:* See conclusion. *Ileum:* The ileocaecal valve and distal ileum appeared normal. *Conclusion:* Excellent views were obtained to the ileum today at colonoscopy. Low rectal anastamosis. Nil else of note. **Recall:** I recommend that undergo a repeat colonoscopy in 3 years time for past history of bowe We will notify at this time. Follow up: If further consultation is appropriate I would be pleased to see your patient again.

If a **future colonoscopy** was planned enter the date or time frame assigned (e.g. 12 months, 5 years, etc.)? ○ ≤ 12 months ◉ 3 years ○ 5 years ○ 10 years ○ Other time frame than the above [ ] ○ Not reported	Colonoscopy report **COLONOSCOPY REPORT** Dear Dr [redacted] **PATIENT:** [redacted] **DOB:** [redacted] **DATE:** [redacted] **MBS:** 32222, 32229 **INDICATION:** Faecal incontinence. Previous prostatectomy **ANAESTHETIST:** [redacted] **FINDINGS** **Anal Canal / Rectum:** Grade 1 Internal Haemorrhoids. **Colon:** Left sided diverticular disease. 3 small polyps removed cold from the caecum and ascending colon. The ascending polyp was not retrieved. The colonic mucosa was normal. Random biopsies taken. **Terminal ileum:** Normal. **Total Time:** 10 minutes **Preparation: Average** **Withdrawal:** 7 minutes **SUMMARY** Three polyps resected and 2 retrieved. Await histology. Repeat colonoscopy in 5 years if health permits. Suggest addition of fibre to diet and consider referral to pelvic floor physiotherapist. With kind regards,
Did the pateint notes provide infomrtion that any of the following impacted their interval decision? ○ No ◉ Yes, Bowel Preparation ○ Yes, Difficult Procedure ○ Yes, Patient Anxiety ○ Yes, Other (Please Enter) [ ]	Colonoscopy report Under “Findings” or “Summary”

<table>
<tr>
<td>
What was the age of the patient at the time of the current episode colonoscopy?

Note: dates in brackets are a guide only. If it is very close, you may need to use an age calculator [click here].

◉ <75 years old (DOB after 1948)
○ 75-80 years old (DOB between 1943 and 1948)
○ >80 years old (DOB before 1943)
○ Not reported
</td>
<td>
COLONOSCOPY REPORT

Dear Dr [redacted]
PATIENT: [redacted] DOB: [redacted]
DATE: [redacted] MBS: 32222, 32229
INDICATION: Faecal incontinence. Previous prostatectomy
ANAESTHETIST: [redacted]

<u>FINDINGS</u>
Anal Canal / Rectum: Grade 1 Internal Haemorrhoids.
Colon: Left sided diverticular disease. 3 small polyps removed cold from the caecum and ascending colon. The ascending polyp was not retrieved. The colonic mucosa was normal. Random biopsies taken.
Terminal ileum: Normal.
Total Time: 10 minutes Preparation: Average
Withdrawal: 7 minutes

<u>SUMMARY</u>
Three polyps resected and 2 retrieved. Await histology.
Repeat colonoscopy in 5 years if health permits.
Suggest addition of fibre to diet and consider referral to pelvic floor physiotherapist.

With kind regards,
</td>
</tr>
<tr>
<td>
What was the sex of the patient?

◉ Male
○ Female
○ Non-Binary
○ Not listed
</td>
<td>
<u>Colonoscopy report</u>

Under “Patient details”
</td>
</tr>
</table>

What was the indication for the future planned colonoscopy?	Colonoscopy report
◉ The patient had a polypectomy (e.g. removal of a polyp) or no clinically significant findings ◉ The patient was having surveillance for family history of colorectal cancer, post colorectal cancer surgery, familial syndromes, or IBD syndromes,	Under "Findings"

	COLONOSCOPY REPORT Dear Dr [redacted] **PATIENT:** [redacted] **DOB:** [redacted] **DATE:** [redacted] **MBS:** 32222, 32229 **INDICATION:** Faecal incontinence. Previous prostatectomy **ANAESTHETIST:** [redacted] **FINDINGS** **Anal Canal / Rectum:** Grade 1 Internal Haemorrhoids. **Colon:** Left sided diverticular disease. 3 small polyps removed cold from the caecum a ascending colon. The ascending polyp was not retrieved. The colonic mucosa was normal. Random biopsies taken. **Terminal ileum:** Normal. **Total Time:** 10 minutes **Preparation: Average** **Withdrawal:** 7 minutes **SUMMARY** Three polyps resected and 2 retrieved. Await histology. Repeat colonoscopy in 5 years if health permits. Suggest addition of fibre to diet and consider referral to pelvic floor physiotherapist. With kind regards,

For the current episode colonoscopy, which of the following best describes the quality of bowel preparation?	Colonoscopy report
○ Satisfactory ◉ Unsatisfactory ○ Not Documented	Under "Findings" or "Summary"

During the current episode colonoscopy, which of the following applies:	Histology report
◉ **Conventional adenoma/s* removed** *tubular, tubulovillous or villous adenoma with low- or high-grade dysplasia ○ **Clinically significant serrated polyp/s** (CSSP) removed** **sessile serrated polyp, traditional serrated polyps and large (≥10mm) hyperplastic polyps ○ **Conventional adenoma/s and CSSP/s removed** ○ **Large (≥20mm) sessile and lateral spreading adenoma/s** with/without removal by endoscopic mucosal resection ○ The patient had no clinically significant (**'normal'**) findings or findings that **didn't require follow-up** colonoscopy	CLINICAL NOTES: HISTOPATHOLOGY CLINICAL HISTORY Incontinence. Random colon bx. Caecal polyp. MACROSCOPY 1) "Caecal polyp" - Two tissue fragments 4-5mm. All in. 1 block. 2) "Random colon" - Four tissue fragments 2-3mm. All in. 1 block. hm MICROSCOPY 1) The large bowel polyp is a tubular adenoma showing low-grade epithelial dysplasia. Muscularis mucosae appears intact and there are no features to indicate malignancy. 2) The sections show large bowel mucosa, including muscularis mucosae. Crypt architecture appears intact and the epithelium is unremarkable. The subepithelial collagen plate is of normal thickness and the lamina propria contains the usual cellular population. Malignancy is not seen. SUMMARY DIAGNOSIS 1) CAECAL POLYP - TUBULAR ADENOMA WITH LOW GRADE DYSPLASIA. 2) RANDOM COLON BIOPSIES - HISTOLOGICAL FEATURES WITHIN NORMAL LIMITS. Reported by H42-B HI-C All tests on this request have now been completed

Number of adenomas? Number ○ 1-2 ○ 3-4 ○ 5-9 ○ >=10 ○ Not reported	<u>Histology report</u> Under “Summary diagnosis”

Size of largest adenoma? Size ○ <10mm ○ >=10mm ○ Not reported	<u>Histology report</u> Under “Macroscopy”

	CLINICAL NOTES: HISTOPATHOLOGY CLINICAL HISTORY Incontinence. Random colon bx. Caecal polyp. MACROSCOPY 1) "Caecal polyp" - Two tissue fragments 4-5mm. All in. 1 block. 2) "Random colon" - Four tissue fragments 2-3mm. All in. 1 block. hm MICROSCOPY 1) The large bowel polyp is a tubular adenoma showing low-grade epithelial dysplasia. Muscularis mucosae appears intact and there are no features to indicate malignancy. 2) The sections show large bowel mucosa, including muscularis mucosae. Crypt architecture appears intact and the epithelium is unremarkable. The subepithelial collagen plate is of normal thickness and the lamina propria contains the usual cellular population. Malignancy is not seen. SUMMARY DIAGNOSIS 1) CAECAL POLYP - TUBULAR ADENOMA WITH LOW GRADE DYSPLASIA. 2) RANDOM COLON BIOPSIES - HISTOLOGICAL FEATURES WITHIN NORMAL LIMITS. Reported by H42-B HI-C All tests on this request have now been completed
Was high grade dysplasia (HGD) or villosity present? HGD or villosity ○ Yes ○ No ○ Not reported	<u>Histology report</u> Under "Microscopy"

	CLINICAL NOTES: HISTOPATHOLOGY CLINICAL HISTORY Incontinence. Random colon bx. Caecal polyp. MACROSCOPY 1) "Caecal polyp" - Two tissue fragments 4-5mm. All in. 1 block. 2) "Random colon" - Four tissue fragments 2-3mm. All in. 1 block. hm MICROSCOPY 1) The large bowel polyp is a tubular adenoma showing low-grade epithelial dysplasia. Muscularis mucosae appears intact and there are no features to indicate malignancy. 2) The sections show large bowel mucosa, including muscularis mucosae. Crypt architecture appears intact and the epithelium is unremarkable. The subepithelial collagen plate is of normal thickness and the lamina propria contains the usual cellular population. Malignancy is not seen. SUMMARY DIAGNOSIS 1) CAECAL POLYP - TUBULAR ADENOMA WITH LOW GRADE DYSPLASIA. 2) RANDOM COLON BIOPSIES - HISTOLOGICAL FEATURES WITHIN NORMAL LIMITS. Reported by H42-B HI-C All tests on this request have now been completed
Is this the patient's first ever (index) colonoscopy? ○ Yes ○ No ○ Not reported	GP referral letter

re.

Phone

Thank you for seeing 62 yrs, Finance officer for an opinion and management. He colonoscopy. As you know he had polyps removed 3 years ago.

His current medications are:

Medication	Dose
Duodart 500mcg; 400mcg Capsule	1 Daily

Allergies:
Nil known.

Past Medical History:

Date	Condition	Details
	Left Inguinal hernia	
27/01/2016	BPH	
2012	BCC excision	Lateral R eye
2014	Polyp, colonic	

Yours faithfully,

Appendix 2 Abbreviations

Abbreviation	Full description
CSSP	Clinically significant serrated polyp
CRC	Colorectal cancer
GP	General practitioner
HGD	High grade dysplasia
HP	Hyperplastic polyps
IBD	Inflammatory bowel disease
SSA	Sessile serrated adenomas
TSA	Traditional serrated adenoma

Appendix 3 Glossary of terms

Term	Definition
General terms	
Colonoscopy	An examination of the large bowel using a camera on a flexible tube, which is passed through the anus.
Faecal occult blood test	A test that can detect microscopic amounts of blood in stools. The most common type of FOBT is the immunochemical FOBT (iFOBT), which directly detects haemoglobin using antibodies specific for the globin moiety of human haemoglobin.
General practitioner (GP)	A medical professional who treats acute and chronic illnesses and provides preventive care and health education to a wide range of patients.
Polypectomy terms	
Advanced adenoma	An adenoma that measures 10mm or more in size. Includes adenomatous polyps greater than or equal to 10 mm in size or with a significant villous component or with high grade dysplasia.
Conventional adenoma	Includes tubular, tubulovillous and villous adenomas.
Clinically significant serrated polyp	Includes sessile serrated adenomas (SSAs), traditional serrated adenomas (TSAs), and large hyperplastic polyps (HPs)
Dysplasia	In relation to patients who have had a colonoscopy, dysplasia is the abnormal growth and development of cells in the colon.
High grade dysplasia (HGD)	Refers to precancerous changes in the cells of the colon under a microscope.
Low grade dysplasia (LGD)	Refers to mild changes in the cells of the colon under a microscope.
Polyp	A small growth protruding from a mucous membrane, such as the lining of the bowel.
Polypectomy	The removal of polyps from the bowel.
Pseudo polyps	Remnants of normal or regenerating colonic mucosa surrounded by ulcerations.

Serrated polyposis syndrome	Defined as the presence of any of the following: 1. at least 5 serrated polyps proximal to the sigmoid colon, with >=2 of these being >10 mm 2. any number of serrated polyps proximal to the sigmoid colon in an individual who has a first-degree relative with serrated polyposis syndrome 3. >20 serrated polyps of any size, but distributed throughout the colon.
Traditional serrated adenoma/s	They are typically serrated polypoid lesions in the distal colon.
Villosity	The state of being villous, a histopathological feature of some tubular adenomas. Villous adenoma is a type of polyp found in the colon or rectum that appears as a cauliflower-like mass.

IBD, family history, familial syndromes and resection terms

Biallelic mutation carrier	An individual with mutation in both copies of the mutY DNA glycosylase (MUTYH) gene.
En-bloc excision	Removal of mass all together or all at the same time.
Familial adenomatous polyposis (FAP)	An autosomal dominant inherited condition in which numerous polyps form, mainly in the colon.
Familial syndromes	Genetic disorders in which inherited genetic mutations in one or more genes predispose a person to developing cancer, particularly at an early age.
First degree relative	An individual's full siblings, parents or children.
High-risk findings	Refers to advanced adenoma (size >=10 mm high grade dysplasia [HGD], villosity) or >= conventional adenomas.
Piecemeal excision	Piecemeal resection is done with snares, to cut off parts of the adenoma piece by piece until the whole adenoma is resected.
Primary sclerosing cholangitis	A disease of the bile ducts where inflammation causes scars within the bile ducts.
Quiescent disease	Inactive disease. May be related to Crohn's disease.
Second degree relative	Someone who shares 25% of a person's genes, such as uncles, aunts, grandparents, half-siblings

Serrated polyposis syndrome	Defined as the presence of any of the following: 1. at least 5 serrated polyps proximal to the sigmoid colon, with >=2 of these being >10 mm 2. Any number of serrated polyps proximal to the sigmoid colon in an individual who has a first-degree relative with serrated polyposis syndrome 3. >20 serrated polyps of any size, but distributed throughout the colon.

Appendix 4 Paper-based audit form

The paper-based audit tool has been provided on the next page to optimise printing

Clinical Colonoscopy Audit Form

Date of audit: Record number: Site: Endoscopist:

What is the age of the patient at the time of the current colonoscopy?	<75 years	75-80 years	>80 years <-**STOP**		
What was the sex of the patient?	Male	Female	Non-Binary	Not listed	
What is the follow recommendation for this colonoscopy? (mark box): A) Surgery/procedure B) Surveillance colonoscopy C) Not surveillance colonoscopy but iFOBT D) No surveillance recommended E) No follow-up documented F) Follow-up in rooms G) Follow-up with GP H) Other ___________________ **STOP** if any option **OTHER** than **B** was selected, **CONTINUE** audit if **B** was selected					
Date of **current episode** colonoscopy:	__/__/__	_____years	__months	NR	
Was a **future** colonoscopy planned?	Yes	No	NR		
- If **Yes**: state the time frame of **future** colonoscopy:	_____years	__months	NR		
Did the patient notes provide information that any of the following **impacted their interval decision**?	No	Yes, Bowel prep	Yes, Difficult procedure	Yes, Patient anxiety	Yes, Other
For the **current episode colonoscopy**, which option best describes the quality of the bowel preparation?	Satisfactory	Un-satisfactory	Not documented		
If patient had >1 colonoscopy, **answer Sections 1A AND 1B**					

If a polypectomy (e.g. removal of a polyp) was completed during the current episode, answer **only one** of the most appropriate options in **SECTION 1A.**

If the reason for the current episode colonoscopy was family history of colorectal cancer, inflammatory bowel disease or resection due to cancer, answer **only one** of the most appropriate options in **SECTION 2**.

SECTION 1A

Current episode colonoscopy results

a) Was there removal of conventional adenomas?					
	Yes	No	NR		
If **Yes**:					
- How many?	1-2	3-4	5-9	≥10	NR
- Size of adenoma/s?	<10mm	≥10mm	NR		
- High grade dysplasia and/or villosity present?	Yes	No	NR		

b) Was there removal of clinically significant serrated polyps* (CSSP) present **with no** conventional adenomas?

*CSSP = sessile serrated adenoma, traditional serrated adenoma, large (≥10mm) hyperplastic polyp

	Yes	No	NR		
If **Yes**:					
- How many?	1-2	3-4	5-9	≥10	NR
- Size of CSSP/s?	<10mm	≥10mm	NR		
- Is dysplasia present in CSSP/s?	Yes	No	NR		
- Traditional serrated adenoma/s present?	Yes	No	NR		
c) Was there removal of CSSP* **with** conventional adenomas? *CSSP = sessile serrated adenoma, traditional serrated adenoma, large (≥10mm) hyperplastic polyp					
	Yes	No	NR		
If **Yes**:					
- How many conventional adenomas?	1-2	3-4	5-9	≥10	NR
- Size of conventional adenoma/s?	<10mm	≥10mm	NR		
- High grade dysplasia and/or villosity present in conventional adenoma/s?	Yes	No	NR		
- How many CSSP/s?	1-2	3-4	5-9	≥10	NR
- Size of CSSP/s?	<10mm	≥10mm	NR		
- Is dysplasia present in CSSP/s?	Yes	No	NR		
- Traditional serrated adenoma/s?	Yes	No	NR		
- Total number of polyps (CSSP/s and adenoma/s)?	1-2	3-4	5-9	≥10	NR
d) Does the patient have a large (>20mm) sessile or laterally spreading adenoma with/without removal by endoscopic mucosal resection?					
	Yes	No	NR		
If **Yes**: Was there en-bloc or piecemeal excision of large sessile and laterally spreading lesions?	En-bloc	Piecemeal	NR		

END OF SECTION 1A

NR = not reported

SECTION 1B

Initial (oldest) colonoscopy results

What were the results from the initial (oldest) colonoscopy?

Removal of a polyp? ☐ CONTINUE

STOP if Normal findings or didn't require follow-up? ☐ No results found ☐ NR ☐

If a polypectomy was undertaken (e.g. removal of a polyp), answer **only one** of the most appropriate options in **SECTION 1B.**

a) Was there removal of conventional adenomas?					
	Yes	No	NR		
If **Yes**:					
- How many?	1-2	3-4	5-9	≥10	NR
- Size of adenoma/s?	<10mm	≥10mm	NR		
- High grade dysplasia and/or villosity present?	Yes	No	NR		
b) Was there removal of clinically significant serrated polyps* (CSSP) present **with no** conventional adenomas? *CSSP = sessile serrated adenoma, traditional serrated adenoma, large (≥10mm) hyperplastic polyp					
-	Yes	No	NR		
- If **Yes**:					
- - How many?	1-2	3-4	5-9	≥10	NR
- - Size of CSSP/s?	<10mm	≥10mm	NR		
- - Is dysplasia present in CSSP/s?	Yes	No	NR		
- - Traditional serrated adenoma/s present?	Yes	No	NR		
c) Was there removal of CSSP* **with** conventional adenomas? *CSSP = sessile serrated adenoma, traditional serrated adenoma, large (≥10mm) hyperplastic polyp					
	Yes	No	NR		
If **Yes**:					
- How many conventional adenomas?	1-2	3-4	5-9	≥10	NR
- Size of conventional adenoma/s?	<10mm	≥10mm	NR		
- - High grade dysplasia and/or villosity present in conventional adenoma/s?	Yes	No	NR		
- How many CSSP/s?	1-2	3-4	5-9	≥10	NR
- Size of CSSP/s?	<10mm	≥10mm	NR		
- Is dysplasia present in CSSP/s?	Yes	No	NR		
- - Traditional serrated adenoma/s?	Yes	No	NR		
- - Total number of polyps (CSSP/s and adenoma/s)?	1-2	3-4	5-9	≥10	NR
d) Does the patient have a large (>20mm) sessile or laterally spreading adenoma with/without removal by endoscopic mucosal resection?					
-	Yes	No	NR		
If **Yes**: Was there en-bloc or piecemeal excision of large sessile and laterally spreading lesions?	En-bloc	Piecemeal	NR		

END OF SECTION 1B

SECTION 2 **Family history of colorectal cancer, familial syndromes, or IBD**					
2a) Did the patient have a colorectal cancer resection?					
	Yes	No	NR		
If yes:					
- Was a resection of a sporadic cancer performed?	Yes	No	NR		
- Did the colonoscopy reveal no advanced adenomas or appear 'normal'?	Yes	No	NR		
Were advanced adenoma/s* present? *An adenoma that measures 10mm or more in size, with/without high grade dysplasia or villosity	Yes	No	NR		
If yes: How many adenomas?	1-2	3-4	5-9	≥10	NR
If yes: Size of adenoma/s?	<10mm	≥10mm	NR		
If yes: was high grade dysplasia and/or villosity present in adenoma/s?	Yes	No	NR		
Were advanced polyps* present? *polyps greater than or equal to 10 mm in size or with a significant villous component or with high-grade dysplasia					
If yes: Size of polyp?	<10mm	≥10mm	NR		
If yes: Is dysplasia present in polyp?	Yes	No	NR		
If yes: Traditional serrated adenoma/s present?	Yes	No	NR		
2b) Does the patient have inflammatory bowel disease (IBD)?					
	Yes	No	NR		
If yes:					
- Date of onset of symptoms	__/__/__		NR		
- Does the patient have at least distal (left sided) ulcerative colitis or Crohn's colitis with involvement of at least one third of the colon?	Yes	No	NR		
- Is the patient with IBD at **high risk** of CRC? (Those with primary sclerosing cholangitis, ongoing chronic active inflammation, prior colorectal dysplasia, evidence of intestinal damage	Yes	No	NR		

with colonic stricture, pseudo polyps or foreshortened tubular colon or family history of CRC at age ≤50 years)					
- Is the patient with IBD at **intermediate risk** of CRC? (Those with quiescent disease, no high risk features or family history of CRC in a first-degree relative)	Yes	No	NR		
- Is the patient with IBD at **low risk** of CRC? (Those with quiescent disease and no other risk factors, and with inactive disease on consecutive surveillance colonoscopies)	Yes	No	NR		
- Does the patient with IBD have high-grade dysplasia?	Yes	No	NR		
- Does the patient with IBD have low-grade dysplasia?	Yes	No	NR		
- Does the patient with IBD have no dysplasia?	Yes	No	NR		
If yes: Has the visible dysplasia been resected?	Yes	No	NR		
2c) Does the patient have a **first degree relative** diagnosed with colorectal cancer?					
	Yes	No	NR		
- If **Yes**: How many relatives?	1	2	≥3	NR	
- If **Yes**: What was their age when diagnosed?	<50	≥50	Unknown	NR	
Does the patient have a **second degree relative** diagnosed with colorectal cancer?					
	Yes	No	NR		
- If **Yes**: How many relatives?	1	2	≥3	NR	
- If **Yes**: What was their age when diagnosed?	<50	≥50	Unknown	NR	
2d) Does the patient have a high-risk familial syndrome?					
	Yes	No	NR		
Familial adenomatous polyposis (FAP)	Yes	No	NR		
If **Yes** to FAP: Are there gastrointestinal symptoms?	Yes	No	NR		
If **Yes** to FAP: Was an adenoma detected?	Yes	No	NR		
MUTYH associated polyposis (MAP)	Yes	No	NR		
If **Yes** to MAP: Is the patient a biallelic mutation carrier?	Yes	No	NR		
If **Yes** to MAP: Was there a polyp detected?	Yes	No	NR		
Lynch syndrome	Yes	No	NR		
If **Yes** to Lynch syndrome: Is the patient >25 years old?	Yes	No	NR		
If **Yes** to Lynch syndrome: Is the age of the youngest affected family member <30 years old?	Yes	No	No affected members	NR	

Peutz-Jeghers syndrome	Yes	No	NR		
If Yes to Peutz-Jeghers syndrome: What is the age of the patient?	Age ____		NR		
If Yes to Peutz-Jeghers syndrome: Were there polyps detected?	Yes	No	NR		
Juvenile polyposis syndrome	Yes	No	NR		
If **Yes** to Juvenile polyposis: What is the age of the patient?	Age ____		NR		
If **Yes** to Juvenile polyposis: Were there polyps detected?					
Serrated polyposis syndrome	Yes	No	NR		
END OF SECTION 2 **END OF AUDIT**					

NR = not reported

Appendix 5a Hospital feedback report template (first report)

[INSERT HEALTH SERVICE DETAILS IN HERE]

Audit of surveillance colonoscopy intervals
[INSERT AUDIT PERIOD e.g., 1 January 2024 to 31 March 2024]

[Date]

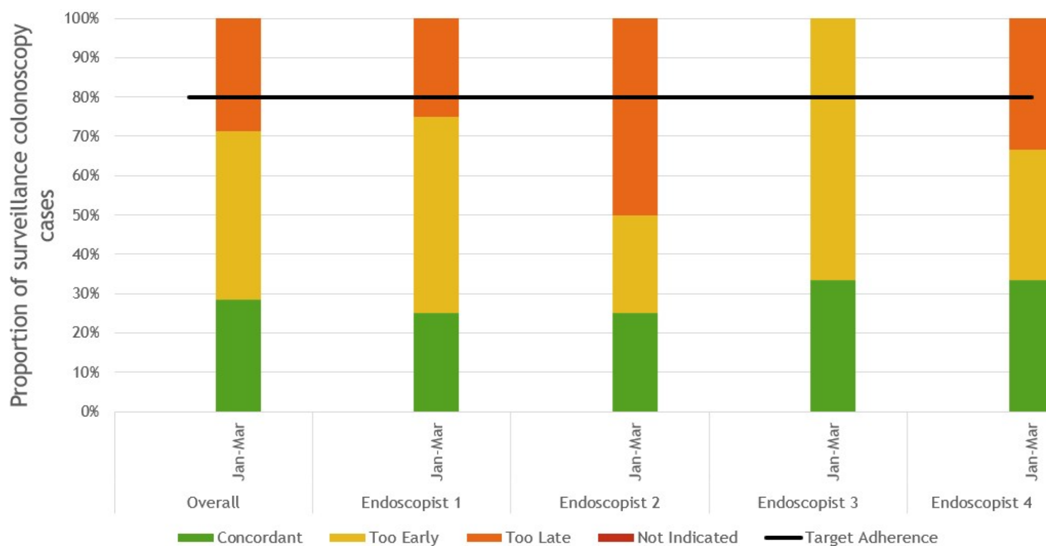
This report summarises concordance with the NHMRC-endorsed Cancer Council Surveillance Colonoscopy Guidelines[1,2] of surveillance interval recommendations made by endoscopists at [Health Service] and audited for the period [INSERT AUDIT PERIOD e.g., 1 January 2024 to 31 March 2024].

200 cases of colonoscopy were reviewed. **144** cases were excluded (not surveillance colonoscopy). **56** were recommended for future surveillance colonoscopy, had complete data to determine concordance and are included in this report.

The audit found, overall, 29% of patients were recommended a surveillance interval consistent with the guidelines for the current period

[FOLLOWING EACH AUDIT PERIOD, THE NUMBER OF CASES ABOVE SHOULD BE UPDATED TO RELFECT THE LATEST INFORMATION]

The figure below summarises overall guideline concordance for all endoscopists at [HEALTH SERVICE] for the current period [INSERT DATES e.g., 1 January 2024 to 31 March 2024]



Reports containing individualised feedback on guideline concordance of surveillance interval recommendations will be provided to individual endoscopists. Best practice resources to support quality improvement are available at https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Colonoscopy_surveillance.

Providing feedback on guideline concordance for surveillance interval recommendations to endoscopists is important as it promotes adherence to best practices, thereby enhancing the quality of care. This targeted approach helps reduce unnecessary procedures, optimises resource utilisation, and ultimately decreases waiting lists and the burden on patients. Access to best practice resources, such as those available on the Cancer Council Australia's Guidelines and Polyp app (https://www.polyp.app), supports continuous quality improvement and ensures that surveillance practices are up-to-date and evidence based.

References

[1] Cancer Council Australia (2018). Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Clinical practice guidelines for surveillance colonoscopy. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/surveillance-colonoscopy

[2] Cancer Council Australia (2023). Cancer Council Australia Colorectal Cancer Guidelines Working Party. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/colorectal-cancer

Appendix 5b Hospital feedback report template (second and subsequent reports)

[INSERT HEALTH SERVICE DETAILS IN HERE]

Audit of surveillance colonoscopy intervals
[INSERT AUDIT PERIOD e.g., 1 April 2024 to 30 June 2024]

[Date]

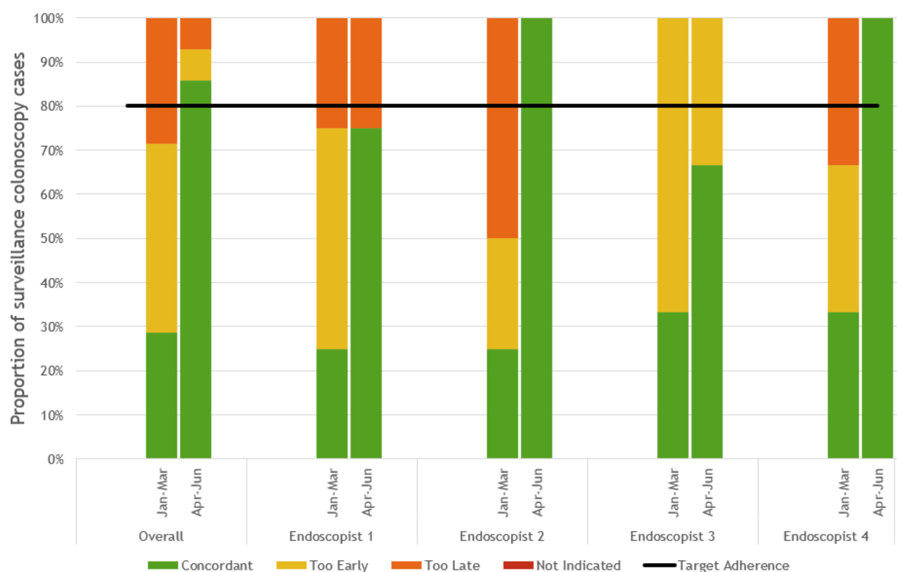
This report summarises concordance with the NHMRC-endorsed Cancer Council Surveillance Colonoscopy Guidelines[1,2] of surveillance interval recommendations made by endoscopists at [Health Service] and audited for the period [INSERT AUDIT PERIOD e.g., 1 April 2024 to 30 June 2024].

200 cases of colonoscopy were reviewed. **121** cases were excluded (not surveillance colonoscopy). **79** were recommended for future surveillance colonoscopy, had complete data to determine concordance and are included in this report.

The audit found, overall, 86% of patients were recommended a surveillance interval consistent with the guidelines for the current period

[FOLLOWING EACH AUDIT PERIOD, THE NUMBER OF CASES ABOVE SHOULD BE UPDATED TO RELFECT THE LATEST INFORMATION]

The figure below summarises overall guideline concordance for all endoscopists at [HEALTH SERVICE] for the current period [INSERT dates e.g., 1 Apr 2024 to 30 June 2024] and the previous audit period for comparison.



Reports containing individualised feedback on guideline concordance of surveillance interval recommendations will be provided to individual endoscopists. Best practice resources to support quality improvement are available at https://wiki.cancer.org.au/australia/Guidelines:Colorectal_cancer/Colonoscopy_surveillance.

Providing feedback on guideline concordance for surveillance interval recommendations to endoscopists is important as it promotes adherence to best practices, thereby enhancing the quality of care. This targeted approach helps reduce unnecessary procedures, optimises resource utilisation, and ultimately decreases waiting lists and the burden on patients. Access to best practice resources, such as those available on the Cancer Council Australia's Guidelines and Polyp app (https://www.polyp.app), supports continuous quality improvement and ensures that surveillance practices are up-to-date and evidence based.

References

[1] Cancer Council Australia (2018). Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Clinical practice guidelines for surveillance colonoscopy. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/surveillance-colonoscopy

[2] Cancer Council Australia (2023). Cancer Council Australia Colorectal Cancer Guidelines Working Party. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/colorectal-cancer

Appendix 6a Endoscopist feedback report template (first report)

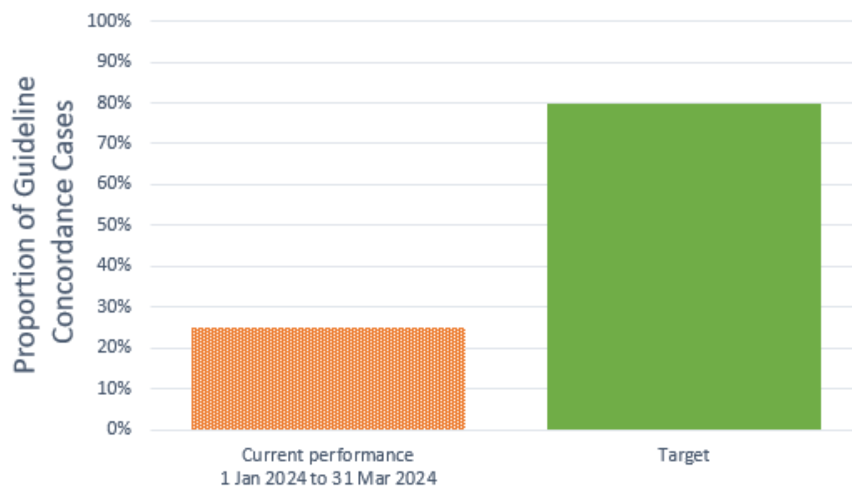
[INSERT HEALTH SERVICE DETAILS IN HERE]

[Date]

Dear Dr [INSERT NAME]

25% of your patients were recommended a surveillance colonoscopy interval consistent with the NHMRC guidelines. The target is 80% guideline concordance.

Why am I receiving this report?	This report contains feedback on your concordance with the NHMRC-endorsed Cancer Council Australia Surveillance Colonoscopy Guidelines[1,2] as a part of [HEALTH SERVICE] quality improvement program conducted between [INSERT AUDIT PERIOD e.g., 01/01/2024 to 31/03/2024].
What is my performance?	Your surveillance interval recommendations for audited cases shows that **25% of your patients had an interval consistent with the guidelines.** This is 55% lower than the target guideline concordance (figure).



What should I do with this information?	More information on your guideline concordance and patient details for non-concordant cases is provided in the tables overleaf. We invite you to reflect on your data and consider whether there are opportunities for you to harmonise your interval recommendations with best practice guidance[1,2].
How can I improve my guideline concordance?	Use Polyp.app, a tool to support guideline uptake (https://polyp.app/ or QR code) Consider the details of your non-concordant cases (Table 2) and whether guideline-recommended intervals may be appropriate for these and other future like cases Take the opportunity to educate your patients about the benefits, harms and best practice guidance for surveillance colonoscopy

	Visit the ***Value In Care – optimising surveillance COLonoscopy (VIC-COL)*** website to access best practice resources, including guidelines, patient resources and webinars on surveillance colonoscopy (https://www.monash.edu/medicine/sphpm/units/clinical-epidemiology-cabrini/vic-col)
How will I benefit from this?	Time spent reviewing this feedback and exploring improvement opportunities will contribute towards your annual **AHPRA Continuing Professional Development (CPD) requirement**.

We hope you have found this information useful. If you have any questions or suggestions on how we can improve this feedback, please contact:

[INSERT REPRESENTATIVES OF THE HOSPITAL QUALITY IMPROVEMENT OR AUDIT TEAM HERE]

References

[1] Cancer Council Australia (2018). Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Clinical practice guidelines for surveillance colonoscopy. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/surveillance-colonoscopy

[2] Cancer Council Australia (2023). Cancer Council Australia Colorectal Cancer Guidelines Working Party. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/colorectal-cancer

Table 1. Timing of your surveillance interval recommendations for this period [INSERT DATES FOR AUDIT PERIOD**] compared to the NHMRC guidelines. [**ADDITIONAL COLUMNS AND RESULTS MAY BE ADDED TO TABLE 1 WHEN NEW AUDIT DATA BECOME AVAILABLE**]**

Timing of your interval recommendations compared to the guidelines	**CURRENT PERIOD [e.g., 1 Jan 2024 to 31 Mar 2024] % (n)**
Concordant	25% (4)
Early	50% (8)
Late	25% (4)
No surveillance recommended	0% (0)

Table 2. Individual patient data for the current period

Highlighted in **bold** are cases where there is a discrepancy between your recommendation and the guidelines. Please note that only you receive this data.

Patient URN	Procedure date	Your recommendation	Guideline recommendation
[insert URN HERE e.g., **010100**]	**18/01/2024**	**5 years**	**10 years**
010101	23/01/2024	3 years	3 years
010102	**23/01/2024**	**3 years**	**≤1 year**
010103	**23/01/2024**	**3 years**	**5 years**
010104	**30/01/2024**	**3 years**	**5 years**
010105	30/01/2024	3 years	3 years
010106	**06/02/2024**	**3 years**	**≤1 year**
010107	06/02/2024	5 years	5 years
010108	**20/02/2024**	**5 years**	**10 years**
010109	05/03/2024	3 years	3 years
010110	**05/03/2024**	**5 years**	**10 years**
010111	**19/03/2024**	**5 years**	**3 years**
010112	**19/03/2024**	**3 years**	**5 years**
010113	**28/03/2024**	**5 years**	**3 years**
010114	**28/03/2024**	**3 years**	**5 years**
010115	**28/03/2024**	**5 years**	**10 years**

Details of non-concordant cases:

Patient URN:	[INSERT URN HERE e.g., 010100]
Current colonoscopy findings	
Type of polyp:	**Conventional adenoma removed**
Number of polyps:	**1-2**
Size of polyps:	**<10mm**
High grade dysplasia or villosity:	**No**
Is this index colonoscopy:	**No**
Index colonoscopy results known:	**Yes**
Index colonoscopy findings	
Type of polyp:	**The patient had no clinically significant findings**
Endoscopist recommendation:	5 years
Guideline recommendation:	10 years
Notes:	

Patient URN:	010102
Current colonoscopy findings	
Type of polyp:	**Conventional adenoma removed**
Number of polyps:	**5-9**
Size of polyps:	**≥10mm**
High grade dysplasia or villosity:	**No**
Is this index colonoscopy:	**No**
Index colonoscopy results known:	**Yes**
Index colonoscopy findings	
Type of polyp:	**The patient had no clinically significant (‘normal’) findings**
Endoscopist recommendation:	3 years
Guideline recommendation:	≤1 year
Notes:	

Patient URN:	010103
Current colonoscopy findings	
Type of polyp:	**Clinically significant serrated polyp removed**
Number of polyps:	**1-2**
Size of polyps:	**<10mm**
High grade dysplasia or villosity:	**No**
Is this index colonoscopy:	**No**
Index colonoscopy results known:	**Yes**

Index colonoscopy findings

Type of polyp: **Clinically significant serrated polyp removed**
Number of polyps: **1-2**
Size of polyps: **<10mm**
High grade dysplasia or villosity: **No**

Endoscopist recommendation: 3 years
Guideline recommendation: 5 years
Notes:

Patient URN: 010104

Current colonoscopy findings

Type of polyp: **Conventional adenoma removed**
Number of polyps: **3-4**
Size of polyps: **<10mm**
High grade dysplasia or villosity: **No**
Is this index colonoscopy: **Not reported**

Endoscopist recommendation: 3 years
Guideline recommendation: 5 years
Notes:

Patient URN: 010106

Current colonoscopy findings

Type of polyp: **Conventional adenoma removed**
Number of polyps: **1-2**
Size of polyps: **≥10mm**
High grade dysplasia or villosity: **No**
Is this index colonoscopy: **Yes**
Bowel preparation: **Unsatisfactory**

Endoscopist recommendation: 3 years
Guideline recommendation: ≤1 year
Notes: Where the bowel preparation is inadequate, repeat colonoscopy should normally be offered within 12 months.

Patient URN: 010108

Current colonoscopy findings

Type of polyp: **Conventional adenoma removed**
Number of polyps: **1-2**
Size of polyps: **<10mm**
High grade dysplasia or villosity: **No**
Is this index colonoscopy: **No**

Index colonoscopy results known: **No**

Family History
Number of 1st Degree relatives diagnosed with colorectal cancer: **1**
Age of 1st Degree relatives at diagnosis: **>60 years**

Endoscopist recommendation: 5 years
Guideline recommendation: 10 years
Endoscopist Notes:

Patient URN: 010110

Current colonoscopy findings
Type of polyp: Conventional adenoma removed
Number of polyps: 1-2
Size of polyps: <10mm
High grade dysplasia or villosity: No
Is this index colonoscopy: Yes

Endoscopist recommendation: 5 years
Guideline recommendation: 10 years
Endoscopist Notes:

Patient URN: 010111

Current colonoscopy findings
Type of polyp: Conventional adenoma and CSSP/s removed
Total number of polyps: 3-4
Size of largest adenoma: <10mm
Size of largest CSSP <10mm
High grade dysplasia or villosity: No
Is this index colonoscopy: Yes

Endoscopist recommendation: 5 years
Guideline recommendation: 3 years
Endoscopist Notes:

Patient URN: 010112

Current colonoscopy findings
Type of polyp: **Conventional adenoma removed**
Number of polyps: **1-2**
Size of polyps: **<10mm**
High grade dysplasia or villosity: **No**
Is this index colonoscopy: **No**
Results of the index colonoscopy known: **Yes**

Index colonoscopy findings	
Type of polyp:	**Clinically significant serrated polyp removed**
Number of polyps:	**1-2**
Size of polyps:	**<10mm**
High grade dysplasia or villosity:	**No**
Endoscopist recommendation:	3 years
Guideline recommendation:	5 years
Endoscopist Notes:	

Patient URN:	010113
Current colonoscopy findings	
Type of polyp:	**Conventional adenoma removed**
Number of polyps:	**3-4**
Size of polyps:	**≥10mm**
High grade dysplasia or villosity:	**No**
Is this index colonoscopy:	**Not reported**
Endoscopist recommendation:	5 years
Guideline recommendation:	3 years
Notes:	

Patient URN:	010114
Current colonoscopy findings	
Type of polyp:	**Clinically significant serrated polyp removed**
Number of polyps:	**1-2**
Size of polyps:	**<10mm**
High grade dysplasia or villosity:	**No**
Is this index colonoscopy:	**No**
Index colonoscopy results known:	**Yes**
Index colonoscopy findings	
Type of polyp:	**Conventional adenoma removed**
Number of polyps:	**1-2**
Size of polyps:	**≥10mm**
High grade dysplasia or villosity:	**Yes**
Endoscopist recommendation:	3 years
Guideline recommendation:	5 years
Notes:	

Patient URN:	010115
Current colonoscopy findings	
Type of polyp:	**Conventional adenoma removed**
Number of polyps:	**1-2**
Size of polyps:	**<10mm**
High grade dysplasia or villosity:	**No**
Is this index colonoscopy:	**Not reported**
Endoscopist recommendation:	5 years
Guideline recommendation:	10 years
Notes:	

Appendix 6b Endoscopist feedback report template (second and subsequent reports)

[INSERT HEALTH SERVICE DETAILS IN HERE]

[Date]

Dear Dr [INSERT NAME]

75% of your patients were recommended a surveillance colonoscopy interval consistent with the NHMRC guidelines. The target is 80% guideline concordance.

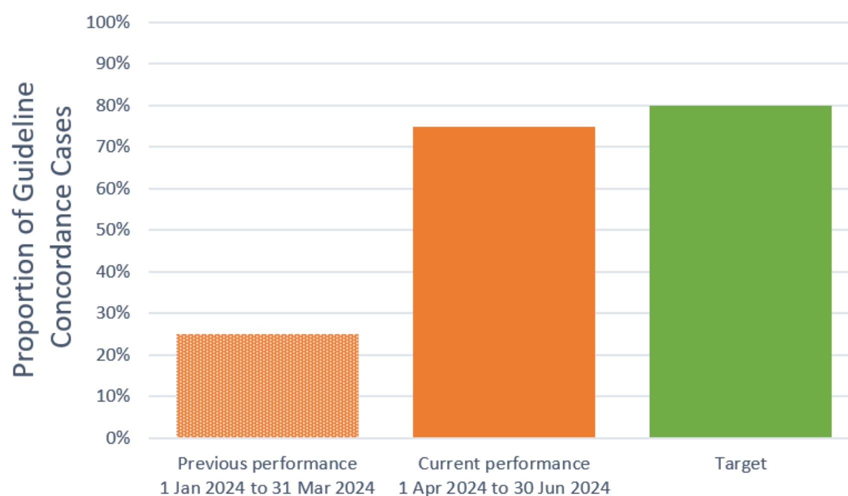
Why am I receiving this report?

This report contains feedback on your concordance with the NHMRC-endorsed Cancer Council Australia Surveillance Colonoscopy Guidelines[1,2] as a part of [HEALTH SERVICE] quality improvement program conducted between [INSERT AUDIT PERIOD e.g., 01/04/2024 to 30/06/2024].

What is my performance?

Your surveillance interval recommendations for audited cases shows that **75% of your patients had an interval consistent with the guidelines.**

This is 5% lower than the target guideline concordance (figure).



What should I do with this information?

More information on your guideline concordance and patient details for non-concordant cases is provided in the tables overleaf.

We invite you to reflect on your data and consider whether there are opportunities for you to harmonise your interval recommendations with best practice guidance[1,2].

How can I improve my guideline concordance?

Use Polyp.app, a tool to support guideline uptake (https://polyp.app/ or QR code)

Consider the details of your non-concordant cases (Table 2) and whether guideline-recommended intervals may be appropriate for these and other future like cases

Take the opportunity to educate your patients about the benefits, harms and best practice guidance for surveillance colonoscopy

	Visit the ***Value In Care – optimising surveillance COLonoscopy (VIC-COL)*** website to access best practice resources, including guidelines, patient resources and webinars on surveillance colonoscopy (https://www.monash.edu/medicine/sphpm/units/clinical-epidemiology-cabrini/vic-col)
How will I benefit from this?	Time spent reviewing this feedback and exploring improvement opportunities will contribute towards your annual **AHPRA Continuing Professional Development (CPD) requirement**.

We hope you have found this information useful. If you have any questions or suggestions on how we can improve this feedback, please contact:

[INSERT REPRESENTATIVES OF THE HOSPITAL QUALITY IMPROVEMENT OR AUDIT TEAM HERE]

References

[1] Cancer Council Australia (2018). Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Clinical practice guidelines for surveillance colonoscopy. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/surveillance-colonoscopy

[2] Cancer Council Australia (2023). Cancer Council Australia Colorectal Cancer Guidelines Working Party. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer. https://www.cancer.org.au/clinical-guidelines/bowel-cancer/colorectal-cancer

Table 1. Timing of your surveillance interval recommendations for this period [INSERT DATES FOR AUDIT PERIOD] **compared to the NHMRC guidelines.** [ADDITIONAL COLUMNS AND RESULTS MAY BE ADDED TO TABLE 1 WHEN NEW AUDIT DATA BECOME AVAILABLE]

Timing of your interval recommendations compared to the guidelines	**CURRENT PERIOD [e.g., 1 Apr to 31 May 2024] % (n)**	**PREVIOUS PERIOD [e.g., 1 Jan to 31 Mar 2024] % (n)**
Concordant	75% (6)	25% (4)
Early	0% (0)	50% (8)
Late	25% (2)	25% (4)
No surveillance recommended	0% (0)	0% (0)

Table 2. Individual patient data for the current period

Highlighted in **bold** are cases where there is a discrepancy between your recommendation and the guidelines. Please note that only you receive this data.

Patient URN	Procedure date	Your recommendation	Guideline recommendation
[insert URN HERE, e.g., 010116]	18/04/2024	10 years	10 years
010117	**23/04/2024**	**10 years**	**5 years**
010118	23/04/2024	3 years	3 years
010119	25/04/2024	3 years	3 years
010120	14/05/2024	5 years	5 years
010121	**14/05/2024**	**3 years**	**≤1 year**
010122	28/05/2024	5 years	5 years
010123	18/06/2024	5 years	5 years

Details of non-concordant cases:

Patient URN: 010117

Current colonoscopy findings

Type of polyp: **Conventional adenoma removed**

Number of polyps: **3-4**

Size of polyps: **<10mm**

High grade dysplasia or villosity: **No**

Is this index colonoscopy: **Yes**

Endoscopist recommendation: 10 years

Guideline recommendation: 5 years

Notes:

Patient URN: 010121

Current colonoscopy findings

Type of polyp: **Conventional adenoma removed**

Number of polyps: **5-6**

Size of polyps: **≥10mm**

High grade dysplasia or villosity: **No**

Is this index colonoscopy: **Yes**

Endoscopist recommendation: 3 years

Guideline recommendation: ≤1 year

Notes:

References

1. Cancer Council Australia (2018). Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party Clinical practice guidelines for surveillance colonoscopy. Retrieved from https://www.cancer.org.au/clinical-guidelines/bowel-cancer/surveillance-colonoscopy