Royal College of Physicians

JAG Joint Advisory Group on GI Endoscopy

JAG accreditation
Global rating scale (GRS) for UK services

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Introduction

The global rating scale (GRS) for endoscopy has been used throughout the UK, Republic of Ireland and beyond to underpin all aspects of a high-quality endoscopy service including clinical quality, safety, patient experience, the environment and the workforce.

The 2021 update to the GRS has been undertaken to:

- consider recent developments in endoscopy, including post-colonoscopy colorectal cancer (PCCRC), the National Endoscopy Database (NED) and the effects of the COVID-19 pandemic
- have a greater focus on outcomes, to demonstrate the measurable and tangible improvements that the standards deliver
- refine the standards where possible to make it easier for endoscopy services to benchmark practice
- absorb the quality assurance standards (used during service assessment) back into the GRS standards, to simplify the process for services gaining accreditation.

This document contains the GRS standards, guidance and accreditation evidence requirements for all adult services in the UK. Some standards may not be relevant where a service is not delivered (for example, providing an inpatient service); endoscopy services can mark this as non-applicable where appropriate.

The standards

Each standard details what an endoscopy service must do to deliver high-quality care. They are aligned to national guidelines and standards where possible. Each standard is given one of three levels:

C this is considered basic practice and should be undertaken as a minimum

B this is best practice and should be met to deliver high-quality care. Services must meet at least level B to move forward with accreditation

A this is exemplary practice which goes above and beyond best practice. All services are encouraged to aim towards this level

The evidence

Services can move forward with an accreditation assessment once they meet all the C and B level standards. Evidence should be uploaded to the JAG website to show compliance for each standard, and suggested evidence is listed in this guide. The evidence is designed to be as simple and easy to gather as possible, while providing a robust assessment of a service. It is not prescriptive and services may provide alternative evidence where appropriate.

For more information please see the JAG website at www.thejag.org.uk.

1. Leadership and organisation

C 1.1: There is a defined leadership and governance structure with clinical, nursing and managerial lead roles, with protected time in their job plans.

Guidance

The leadership team should invite staff feedback to assess their effectiveness, for example a 360 feedback process.

Evidence requirements

- A summary description of the leadership roles and responsibilities for the service (clinical lead, nurse lead, training lead, management leadership and support), including the time commitment allowed to support leadership functions.
- Feedback about leadership and governance performance.

C 1.2: Clear information is available about the range of endoscopy procedures provided at this and all associated sites.

Guidance

The service description and procedures offered should be available to referrers, patients and their carers, usually on a website. It should be in appropriate formats and languages for the local population, and be easily accessible.

It should state if the service is a standalone service or operates on multiple sites, whether patients may be referred to other organisations, and any outsourcing and insourcing arrangements.

Evidence requirements

- The description of the service including all linked or affiliated services, including relationships with other endoscopy services, patient groups, and services that share a common purpose.
- A summary description of the service for referrers, patients and their carers. This should be on a website and available in paper format.
- Feedback from referrers, patients and their carers (see 14.5).

C 1.3: There are defined operational, nursing and governance meetings within the service that support organisation and delivery.

Guidance

The endoscopy users group (EUG) is the main endoscopy governance meeting. Communication structures should show how communication happens with all staff including alerts, changes in practice and how decisions are communicated.

Evidence requirements

- A description of the governance structure including an organisational structure and lines of reporting.
- A communication structure for the service including:
  - operational meetings to support planning and delivery
  - governance meetings (EUG or other) including terms of reference/agenda
  - workforce meetings (nursing, admin etc).
- Assessment of impact of communication structure through staff feedback (see 14.5).

C 1.4: There are processes and timescales to review and maintain all policies and standard operating procedures.

Guidance

This might be a hospital document management system or locally devised system. Owners and review dates should be recorded on all key documents.

Evidence requirements

- Evidence of a system of document management including owners and dates of review for all key documents.

C 1.5: There is an annual audit plan for the service with named leads and timescales.

Guidance

See the JAG quality and safety guidance.

Evidence requirements

- Annual rolling audit plan including named leads and timescales (this should include clinical and other audits, ie patient and staff).

B 1.6: The leadership team has managerial, administrative and technical support (such as IT) to organise and deliver the service effectively, including access to timely and appropriate data.

Guidance

This includes a National Endoscopy Database (NED)-compliant endoscopy reporting system and other data capture systems for productivity.

Evidence requirements

- Summary of managerial, administrative and technical support for the service and key functions.

B 1.7: The leadership team review and plan how to meet the service's strategic objectives annually, including for any service developments.

Guidance

This is also an opportunity to look back at what has been achieved. Services should consider how they engage with local populations and their representative organisations.

Evidence requirements

- Annual review of the service strategy, objectives and resources including a plan that summarises deliverables for the service.
- A business plan (if applicable) to support new developments (eg kit, workforce, environment, capacity).

B 1.8: The leadership team and workforce engage in innovation, sharing quality improvements, and research (where appropriate) with other endoscopy services locally, regionally and/or nationally.

Guidance

This could be attendance at learning events, visiting other services, sharing methodology etc. See the JAG website for learning opportunities, for example the safety case of the month.

Evidence requirements

- Examples of innovation, sharing of quality improvements or research.

A **1.9: The service has a 'green endoscopy' working group to reduce the environmental impact of the service and initiates at least one environmental initiative.**

Guidance

An example of this is an initiative to reduce waste in endoscopy. The service should reflect hospital objectives to improve environmental impacts.

2. Safety

C 2.1: Adverse events and key safety indicators are recorded, monitored and acted upon.

Guidance

Services should use their organisation-wide adverse events management system to show how near misses and adverse events are managed and learned from.

The British Society of Gastroenterology (BSG) outcomes that require monitoring are described in the JAG quality and safety guidance.

Evidence requirements

- The service operational policy that summarises safety/adverse event monitoring and reporting in endoscopy. Note: this must not be a 'group-wide' policy for endoscopy or national policy. A template may be provided by the hospital groups to be followed, but must be specific to the service being assessed.

C 2.2: A pre- and post-procedure safety checklist is used for each endoscopy list.

Guidance

See the World Health Organization (WHO) safe surgery checklist.

Evidence requirements

- Example use of organisation approved validated safety checklist (eg WHO safety checklist).

C 2.3: Patient's fitness for oral bowel cleansing agents is assessed and documented prior to bowel preparation being dispensed.

Guidance

See the European Society of Gastrointestinal Endoscopy (ESGE) guidelines.

Evidence requirements

- Bowel preparation and dispensing policy (refer to 8.3).

C 2.4: The leadership team review adverse events at least every 3 months. This is shared locally and nationally where appropriate.

Guidance

Actions should be agreed and recorded at the EUG meeting or other appropriate governance meeting. In smaller services this may be a joint meeting with another service (for example, theatres).

Evidence requirements

- Named safety lead for the service.
- EUG minutes showing safety as a standard agenda item.
- Examples of risk and safety outcomes, actions and learning.
- Risk assessment of changes in practice due to COVID-19, for example location of pathways.

C 2.5: There are core clinical protocols to support patient safety.

Guidance

See the BSG website for clinical guidelines.

Evidence requirements

- The endoscopy clinical protocols for management of:
  - diabetes
  - anticoagulation including novel oral anticoagulants (NOACs)
  - antiplatelet agents
  - antibiotic use in patients undergoing endoscopy
  - implantable devices in patients undergoing endoscopy
  - safe prescribing and distribution of oral bowel preparation
  - screening protocol for COVID-19.

C 2.6: The endoscopist and practitioners meet before each list to identify any potential risks or issues.

Guidance

The focus of this should be to share safety learning and to identify potential patient, environment, kit, infection control and staffing issues.

Evidence requirements

- Standard operating procedure (SOP) for team brief and checks before each list.
- Protocol for patient assessment, risk assessment and management of procedure including specific instructions.
- Examples of impact and learning if applicable (links to 2.3).

C 2.7: A lead clinician is responsible for local integrated care pathways for both upper and lower gastrointestinal (GI) bleeding and their clinical governance.

Guidance

This does not usually apply if the service does not have an out-of-hours bleed service.

The National Institute for Health and Care Excellence (NICE) has an acute upper gastrointestinal bleeding in adults quality standard.

Evidence requirements

- A summary description of the leadership role and responsibilities for upper and lower GI bleeding.

B 2.8: All patients with acute upper and lower GI bleeding are appropriately managed in line with national guidelines, including risk stratification to ensure timely investigation and treatment.

Guidance

See the BSG acute upper GI bleed care bundle.

See the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report on GI bleeds

Evidence requirements

- Policy and SOP for the management of GI bleeds, ie major haemorrhage policy (for services without an out-of-hours bleed service this includes immediate action and transfer arrangements).

For services that provide an out-of-hours bleed service:

- Data to support that 75% of patients admitted with acute upper GI bleeding who are haemodynamically stable receive endoscopy within 24 hours of admission.
- Data to support that 50% of the quality measures in the 2016 NICE guidelines for acute upper gastrointestinal bleeding have been met.
- Action plan to support improvements where the guidelines have not been met.
- Minutes from the last year to show that out-of-hours GI bleeding has been assessed, preferably against the NICE guidelines.
- Risk register and mitigation plan.

B 2.9: There is a process for identifying, reviewing and reporting deaths and unplanned admissions related to endoscopy.

Guidance

Outcomes of reviews should be reported through EUG/governance meetings.

In the non-acute sector it is expected that every effort is made to identify this information. Services should conduct a root cause analysis (RCA) of any cases that they are made aware of.

Evidence requirements

- RCA of known deaths and unplanned admissions.
- Minutes demonstrating an annual review of mortality and morbidity in endoscopy and that 'lessons learnt' are recorded and acted upon.
- SOP for reporting of deaths and unplanned admissions possibly related to endoscopy and how they are then reviewed.

3. Comfort

C 3.1: Patients receive timely information providing a realistic description of the level of discomfort possible during the procedure (for paediatric patients, this is relevant for those under sedation).

Guidance

Patient information and pre-assessment should explain potential discomfort to patients and the range of options for sedation.

See the JAG quality and safety guidance.

Evidence requirements

- The policy and process for patient comfort, monitoring and reporting in endoscopy. This can be included as part of the operational policy.

B 3.2: Practitioners monitor and record patient pain and comfort levels during and after the procedure using a validated scoring scale.

Guidance

A comfort assessment should cover all endoscopy procedures, irrespective of sedation level.

It is the endoscopy practitioner's responsibility to tend to the needs of the patient during the procedure and to monitor their comfort. Because the endoscopist's attention is focused on the procedure, it is believed that the endoscopy practitioner is the best judge of the level of discomfort. Sedation may also affect patients' perceptions of discomfort.

Patients should also be asked directly about their pain and comfort levels during and after the procedure.

Evidence requirements

- A service operational policy including a section on comfort monitoring and reporting in endoscopy.
- Patient feedback survey, results and action plan which includes patient feedback on comfort.
- Evidence that both practitioner- and patient-reported levels are included in patient comfort monitoring and reporting.

B 3.3: Patients are supported if they become distressed or wish to stop the procedure.

Guidance

The comfort of patients during the procedure is everyone's responsibility. The nursing team has a role to act as the patient's advocate and ensure that the procedure is paused and reviewed where is there is distress.

Evidence requirements

- Withdrawal of consent policy.
- Process to support patients during the procedure and define the role of the practitioner lead in the room.

B 3.4: Patient comfort scores are reviewed at least twice per year by the leadership team and are fed back to individual endoscopists. If comfort scores fall below agreed levels, the endoscopist's practice is reviewed by the clinical lead and/or governance committee.

Guidance

Feedback of comfort levels to endoscopists is important to reassure those who are causing low levels of discomfort and to identify where technique or sedation practice could be improved.

See JAG guidance on managing endoscopist underperformance.

Evidence requirements

Use mandatory template 1 and 2

- Individualised endoscopists' 'anonymised' data on patient comfort level reports. This data should be linked with other information in the quality standards to form one report.
- Evidence of feedback to individual endoscopists at least twice per year.
- The service policy and process for supporting endoscopists whose patient comfort scores fall below agreed levels, including action and review timescales).

A 3.5: The service is able to use CO2 insufflation and provide N2O inhalation for patients undergoing GI procedures.

A **3.6: The service is able to offer a full range of sedation techniques to maximise comfort, minimise patient anxiety and perform highly technical endoscopy in line with nationally accepted guidelines.**

Guidance

A full range of sedation techniques means that the patient is aware of the full options available to them and what is safe and appropriate for that patients' needs.

4. Quality

C 4.1: Individual endoscopists are given feedback on their procedure key performance indicators (KPIs) at least twice per year.

Guidance

This includes all endoscopists who are working in the service and should include locums who are employed on contracts. New locums are expected to provide their KPI data and be observed scoping.

JAG would expect that any new endoscopist is assessed at least once to assess competence and familiarise with equipment etc.

Evidence requirements

Use mandatory templates 1 and 2

- Process to monitor the relevant quality standards for endoscopy.
- EUG minutes showing evidence of feedback from KPI audits and agreed action plans (2 x sets).
- Process to assess the KPIs and competency of any new endoscopist. This should be for all grades including new consultants, trainees and, critically, locums.
- Evidence that individual endoscopists are given feedback on their procedure KPIs at least twice a year. This data should be linked with other information in the quality standards to form one report (eg comfort).

B 4.2: Individual endoscopists are given feedback on their safety outcomes at least annually.

Guidance

The specific BSG safety outcomes that require review are described in the JAG quality and safety guidance.

Evidence requirements

- Evidence that individual endoscopists are given feedback on their safety outcomes at least annually, eg. PCCRC/PEUGIC
- Minutes that show that any PCCRC/PEUGIC that have arisen in the service (cancer diagnosed within 3 years after a colonoscopy/ Gastroscopy has been performed) have an RCA with action planned as required.
- Operational policy which describes how PCCRCs/PEUGIC are identified and acted upon.

C 4.3: If individual endoscopist performance levels are not achieved, the service manages underperformance according to national guidance.

Guidance

See JAG guidance on managing endoscopist underperformance).

Evidence requirements

- The operational policy and process including a section on supporting endoscopist performance and escalation processes.
- Evidence of application of the process (if applied) and outcomes.

B 4.4: An endoscopy reporting system (ERS) captures immediate procedural and performance data. The ERS actively uploads all GI endoscopy procedures to the National Endoscopy Database (NED) using compliant software and meets ongoing data validation requirements.

Guidance

This includes cases outside the endoscopy unit, such as emergency procedures, endoscopic retrograde cholangiopancreatography (ERCPs) performed in radiology and paediatric patients.

See the NED website.

- No evidence required – JAG will check whether the service uses NED compliant software and meets ongoing data validation requirements prior to booking an assessment.

B 4.5: The service collects data for inpatients who undergo endoscopy, including indication, waiting times and relevant auditable outcomes.

Guidance

This does not usually apply if the service does not have an inpatient service.

Evidence requirements

- Report showing service waiting times for inpatients and outcomes for inpatients that undergo endoscopy.
- EUG minutes showing evidence of agreed action plans.

B 4.6: The service collects details of all 'off unit' GI endoscopy that occurs in the organisation and captures this on the ERS.

Guidance

This does not usually apply if the service does not undertake endoscopy outside the main unit.

Where endoscopy is performed outside of the main unit, for example in outpatients, theatre or radiology, the service should identify patients and assess their indications and outcomes against BSG auditable outcomes and quality indicators.

Evidence requirements

- The service operational policy including a section on ERS use and off unit endoscopy.

5. Appropriateness

C 5.1: Referral guidelines are available for all procedures in an accessible form for referrers.

Guidance

The service should have one set of referral guidelines for all procedures which are referenced in the operational policy and are easily available through websites for referrers. All endoscopists should follow nationally accepted criteria (NICE, BSG).

Evidence requirements

- Agreed service referral guidelines including any changes resulting from COVID-19.

The service operational policy including:

  - a summary of processes for referrals
  - guidelines for surveillance addition/ selection
  - type of services offered, eg direct access.

C 5.2: There is a local policy for vetting referrals. Endoscopy referral forms have sufficient clinical information to permit vetting of the appropriateness of the referral against guidelines.

Guidance

A strong emphasis on vetting is essential to ensure that patients are on the correct pathways for diagnosis and treatment.

In the non-acute sector, all services completing NHS contracts are expected to follow the agreed terms for vetting cases.

Evidence requirements

- The service operational policy including:
  - vetting practices including outpatients and inpatient referrals, and the management of inappropriate referrals
  - the process for validation of surveillance cases.
- Details of changes to vetting and validation practices to reduce unnecessary referrals following the COVID-19 pandemic.
- Where surveillance is not routinely undertaken, a policy defining the management pathway and responsibility for patients requiring follow up procedures. eg Barrett's, colonic polyps, gastric intestinal metaplasia (IM).

C 5.3: All referrals from non-endoscopists within primary and secondary care are vetted by an endoscopist who performs that procedure, unless 'straight to test' protocols exist.

Guidance

Non acute services completing NHS contracts should follow the agreed direct access criteria in any agreements.

Evidence requirements

- Service vetting SOP or section in operational policy.
- Examples of NHS contracts with agreed direct access criteria.

B 5.4: Inpatient endoscopy requests are triaged daily to prioritise clinically urgent cases.

Guidance

This does not usually apply if the service does not have an inpatient service.

Vetting of urgent inpatient requests should prioritise the most urgent cases and reduce length of inpatient stay. This should include good two-way communication between the referring teams and the endoscopists, particularly for emergency cases.

Evidence requirements

- Service inpatient vetting SOP or section in operational policy.
- Examples of completed anonymised referrals. If referrals are undertaken electronically, this will be assessed during the site assessment.

B 5.5: All surveillance procedures are clerically and clinically validated according to national guidance at least 2 months prior to the due date.

Guidance

This does not apply if the service does not undertake surveillance procedures.

Patients should be advised that their procedure may be cancelled or deferred in future (eg new surveillance interval guidelines).

Evidence requirements

- Service vetting SOP or section in operational policy.
- Details of progress for validating patients against the 2019 surveillance guidelines (if guidelines are not completely implemented).

B 5.6: The vetting process is reviewed annually and action plans are created to address any issues.

Guidance

Outcomes and action plans should be agreed at the endoscopy EUG.

Evidence requirements

- Review or audit of effectiveness of vetting process and outcomes.
- EUG minutes and action plan.

6. Results

C **6.1: Endoscopy reports for all inpatients are added to the patient record before the patient leaves the department.**

Evidence requirements

- If endoscopy is preformed outside the unit, evidence that there is local access to the ERS to ensure timely reporting.
- Process for producing/printing reports post-COVID -19.

C **6.2: There is a process for referring patients with a suspected or definitive cancer diagnosis to the multidisciplinary team (MDT).**

Evidence requirements

- The service operational policy including:
  - the processes for ongoing management of patients with suspected cancer, including MDT reporting and patient access to support from relevant cancer specialist practitioners.
- For the non-acute sector, the policy for referral to a local MDT team.
- Policy for referral to a specialist practitioner competent other to provide support patients within 24 hours of their diagnosis.

B 6.3: There is a process for pathology, to track malignant histology and to ensure prompt referral for management and treatment.

Guidance

There should be a structure and process to inform the appropriate local cancer team as soon as is practicable after diagnosis including periods when consultants are on annual leave.

Evidence requirements

- SOP for specimen labelling, recording and reporting.
- Policy stating who is responsible to receive, review and act on histology results.

B 6.4: Endoscopy reports are completed on the day of the procedure and include follow-up details, and are sent to the patient's GP and the referring clinician (if different) within 24 hours of the procedure.

Guidance

It is appreciated that many services are aiming for 7-day working and the reports may not be dispatched at the weekend within 24 hours, however, it is expected that a service will work towards this. JAG recommends that reports are sent electronically.

Evidence requirements

- Process for producing/printing reports.
- If endoscopy is preformed outside the unit, evidence that there is local access to the ERS to ensure timely reporting.

B 6.5: There is a process for the responsibility of clinical actions resulting from the pathology reports. Pathology reports are accessible with no undue delay.

Guidance

There should be a process for determining at the time of the endoscopy whether a referrer should be sent additional information. The endoscopist who has performed the procedure may be best placed to do this as they have specialist knowledge to interpret the results and determine further actions.

If the patient has a planned outpatient appointment to review the endoscopy and pathology report, then this would fall outside this measure.

Evidence requirements

- The service operational policy including sections on:
  - who is responsible to receive, review and act on histology results
  - the processes for reporting and timelines for pathology in endoscopy
  - the process for endoscopy reports to be sent to the patient's GP and also to the referring clinician
  - the process for annual leave cover and reviewing of pathology results.

B 6.6: If a cancer is suspected, the patient is referred to a relevant cancer clinical nurse specialist (CNS) who offers contact with the patient before or soon after discharge.

Guidance

Some endoscopy services will not have cancer clinical nurse specialists or an equivalent other professional on site. It is expected that a SOP will detail how to inform the local CNS within 1 working day of the procedure so they can contact the patient.

If a CNS is not available due to workforce gaps or other reasons then a suitably competent person must be available to respond and support patients.

Evidence requirements

- SOP to support patients with a cancer diagnosis.

7. Respect and dignity

C 7.1: There is a respect, dignity and security policy, which includes the care of adults and children accessing the service.

Guidance

This should include how the endoscopy service provides a comprehensive service to all patients irrespective of gender, ethnicity, disability, age, sexual orientation, religion, beliefs, gender reassignment, pregnancy and maternity, or marital or civil partnership status.

Examples of how respect and dignity might be applied in practice in endoscopy include:

- staff introductions, name badges, interpretation and translation policy (to ensure that patients and carers whose first language is not English get the same level of service as others)
- patient information including pictures and sign language
- dementia-friendly signs
- privacy curtains/clips in toilets and bathrooms and some examination rooms
- side-tying gowns, larger size wheelchairs/ trolleys, flashing vibrating devices to alert hard of hearing patients.

See the JAG environment guidance.

Evidence requirements

- The service operational policy, including sections on:
  - equality and diversity
  - the patient pathway and privacy and dignity needs
  - confidentiality
  - security procedure
  - supporting patients with mental or physical disabilities or additional learning needs
  - supporting transgender patients
  - meeting the nation-specific requirements for both gender and pre- / post-procedure segregation
  - access to a quiet room for any clinical conversations to be held in private.
- SOPs and risk assessment of changes made to the environment and pathway to maintain patient safety, privacy and respect in light of COVID-19.

C 7.2: There is a safeguarding policy for adults and children within the department.

Guidance

There should be a specific description of how vulnerable patients are cared for contained within the operational policy.

Evidence requirements

- The service operational policy, including a section on:
  - safeguarding adults and children (if applicable)

C 7.3: There is a nominated dignity champion within the service.

Guidance

A dignity champion:

- stands up and challenges disrespectful behaviour
- acts as a good role model by treating other people with respect, particularly those who are less able to stand up for themselves
- speaks up about dignity to improve the way that services are organised and delivered
- influences and informs colleagues
- listens to and understands the views and experiences of patients.

Evidence requirements

- Details of the nominated member of staff for privacy and dignity.
- The service operational policy, including a section on:
  - staff responsibilities for privacy and dignity
  - links to patient involvement and feedback.

C 7.4: There are a range of communication methods and materials to inform patients about what they should expect from the service (such as a website, written information, or specialised communication, eg pictures).

Guidance

Communication methods and approaches will be different for each service and therefore must reflect both the needs of patients and the service, eg website, written information and specialised communication such as pictures.

See 7.1

Evidence requirements

- Link to service website with patient information and resources.
- Example of patient information that reference patient's rights and expectations

C 7.5: Staff are trained to act with discretion and respect towards all patients and carers.

Guidance

Training for staff may be organisation wide or bespoke for the endoscopy service.

Evidence requirements

- Staff training and updates regarding respect and dignity, which includes equality and diversity.

C 7.6: The use of family and friends as interpreters is discouraged unless it is the patient's (or carer's) choice. If used, this is documented.

Guidance

It is the patient's choice if they wish to use their family or friends as interpreters. This should be confirmed by an interpreter (usually by phone) and documented in the patient's file.

Evidence requirements

- The service operational policy, including sections on:
  - the use of interpreters including the use of family members or carers.

B 7.7: Patients' confidentiality, privacy and dignity is protected throughout the pathway.

Guidance

The JAG environment guidance details measures to maintain confidentiality, privacy and dignity. Of particular importance is:

- here is an area for clinical conversations to be held in private where it cannot be heard by other patients or relatives, eg consent-taking and delivering sensitive news
- relatives are not permitted in clinical areas unless in the patient's best interest. There may be incidences where this is unavoidable, eg carers or those with other needs. This should be recorded in the patient notes.
- patient-identifiable material is not displayed in areas accessible to patients or the public.

Evidence requirements

- Patient involvement strategy for the endoscopy service (ie involvement in review of patient materials, patient pathway, patient stories and EUG).
- Patient survey for the endoscopy service that covers privacy and dignity (and includes feedback from patients who are insourced or outsourced to another provider).
- Other sources of immediate patient feedback on the day of the procedure (eg friends and family test or other). Summary of results and actions feedback at relevant meetings.
- EUG minutes showing evidence of patient survey feedback with agreed action plans.

8. Consent and patient information

C 8.1: Patient information for all relevant procedures is given to patients ahead of the procedure (diagnostic and therapeutic).

Guidance

See 7.1 and 7.4

Consideration should be given to alternative options to address patients with additional language or learning needs, for example having patient information in different languages or a picture board that patients can point to.

Evidence requirements

- A summary list of all patient information with dates of review.
- At least three examples of patient information, ideally colonoscopy, gastroscopy and flexi sigmoidoscopy (and ERCP if undertaken).
- Alternative patient information options to address language and learning needs.

C 8.2: There is a policy for consent including withdrawal of consent during a procedure (whether awake or under conscious sedation).

Evidence requirements

- Hospital consent policy
- The service operational policy including a section consent in endoscopy and withdrawal of consent (this may be a separate SOP).
- A process for high-risk and vulnerable groups, as defined by the service, and how they are supported with consent before the date of the procedure.
- Risk assessment of obtaining consent within the patient pathway, in light of COVID-19 and infection control.

C 8.3: The requesting clinician documents a patient's fitness for oral bowel cleansing agents prior to dispensing bowel preparation.

Guidance

It is essential to verify that the patient is fit enough to undergo the procedure. This includes being able to take bowel preparation, lay flat and move for colonoscopy. In services where non-PEG based laxatives are used, protocols need to ensure renal function has recently been assessed with appropriate advice given. It is the responsibility of the accepting clinician to ensure that this happens.

Evidence requirements

- Evidence that the requesting clinician documents a patient's fitness for oral bowel cleansing agents prior to bowel preparation being dispensed.

C **8.4: Patients and carers are given sufficient time to ask questions or express concerns. Consent forms are signed by the patient or carer before the patient enters the endoscopy room. There are processes for those who cannot sign the form and the consent process is undertaken by a trained professional.**

Evidence requirements

- See 8.2.
- Policy and/or SOP for patients who cannot sign their consent form.

C **8.5: 'High-risk' patients and patients scheduled for 'high-risk' procedures are pre-assessed to discuss the risks and benefits of the procedure in line with informed consent, and this is documented.**

Guidance

See 2.5.

The assessment process allows individual patient and procedure risks to be identified and managed. Pre-assessment may take the form of remote, telephone, video or face to face assessments.

High-risk patients are identified as those with an American Society of Anesthesiologists (ASA) score of 3 or greater where an underlying clinical condition or medications may make them more likely to have a complication, eg severe diverticulosis, patients on anticoagulants and patients having general anaesthesia.

High-risk procedures include planned therapeutic oesophagogastroduodenoscopy (OGD), percutaneous endoscopic gastrostomy (PEG), endoscopic retrograde cholangiopancreatography (ERCP), planned endoscopic submucosal dissection (ESD) and planned endoscopic mucosal resection (EMR). This list is not exhaustive.

Evidence requirements

- Policy and/or SOP for pre-assessment of high-risk patients attending for high-risk procedures. of consent (this may be a separate SOP).

B 8.6: The consent process for inpatients is commenced on the ward, by a competent individual.

Guidance

This does not usually apply if the service does not have an inpatient service.

Evidence requirements

- Policy and/or SOP for pre-assessment of inpatients and preparation for the procedure.

B 8.7: There is a process to review patient information annually to reflect patient feedback and changes in practice or risks.

Guidance

This activity should be included in the EUG or equivalent.

Evidence requirements

- EUG meeting minutes or equivelant.
- See 1.5.

B 8.8: Appropriate patients are routinely pre-assessed, either by telephone or in person.

Guidance

The service should define the appropriate groups of patients for a routine pre-assessment service. It may include all patients or target-specific procedures such as colonoscopy and ERCP.

Evidence requirements

- Policy and/or SOP for pre-assessment of patients.

9. Patient environment and equipment

C **9.1: There is a description of the facilities available for patients and referrers.**

Guidance

All areas used by the service must meet the specific needs of patients (including children and those with particular needs) and staff, and comply with national guidance (eg vulnerable adults, single-sex accommodation etc).

Evidence requirements

- A description of the facilities (outpatient and inpatient) available to support the service.
- Website link for patients/carers/professionals.
- The service operational policy, including a section on:
  - accommodation and those with particular needs.
  - children in endoscopy, if applicable.

C **9.2: UK: Decontamination equipment is tested and validated according to national guidance and action is taken on results which fall outside acceptable parameters. ROI: Guidelines for endoscope decontamination are available in the service in written and/or electronic form.**

Guidance

Decontamination equipment and associated machinery includes endoscope washer disinfectors (EWDs), reverse osmosis plants, endoscope storage cupboards etc. Testing and validation should be in line with national requirements, eg Choice framework for local policy and procedures 01-06 – Decontamination of flexible endoscopes: Testing methods ((cfPP01/06).

Evidence requirements

- An in-year IHEEM audit report (mandatory template 5) completed and signed by an authorised engineer for decontamination (AED) with an action plan to resolve any identified issues.
- If decontamination is outsourced, evidence of meetings to ensure that the outsourcing arrangement, audits and issues are reviewed and acted upon. This includes the tracking and traceability of scopes.
- The organisation's decontamination policy.
- SOPs for decontamination that support local practice and processes.

C 9.3: The facilities and environment support service delivery.

Guidance

The infrastructure/facilities meet the specific needs of all patients (including children and those with particular needs) and staff. This includes assessment against the environment guidance.

This includes HTM requirements for ventilation and decontamination.

Evidence requirements

- Completed environment checklist (mandatory template 4), including an action plan to address deficit. This should include any extra controls or requirements following COVID-19.
- An infection control audit of the endoscopy and decontamination environments carried out by the local infection prevention team with an action plan to resolve any issues (this could be an Infection Prevention Society (IPS) audit or a locally designed audit). SOPs for infection control practices and patient pathway management.
- Confirmation of procedure room ventilation air changes (annual check report).

C 9.4: There is an endoscopy management lead and decontamination user (manager) responsible for the endoscopy facility and environment management.

Guidance

The management lead for decontamination within endoscopy must fulfil the role and requirements as identified in the respective national guidance. Where decontamination is undertaken outside endoscopy, the nominated person must show how this links to the staff using the equipment within the endoscopy service.

Where decontamination is overseen outside the unit, or by another authorised manager, procurement and management may fall within the remit of two people.

Evidence requirements

- The service operational policy, including a section on roles and responsibilities for the patient areas, decontamination processes and infection control, and health and safety in the service.

C 9.5: There is an annual review of equipment including endoscopes and a process for replacement.

Guidance

This should include a risk assessment of kit if not replaced.

Evidence requirements

- A matrix of endoscopes with maintenance contracts and checks, and plans for replacement. A planned preventative maintenance schedule and full service history records of all endoscopy equipment.

B 9.6: All areas are well maintained and support efficient patient flow and ergonomic and efficient working. Access is restricted as appropriate.

Guidance

See the JAG environment guidance.

The patient pathway/facilities will be examined during the site assessment.

Evidence requirements

- SOP or operational policy for unit access and restrictions.

B 9.7: Systems maintain and quality assure equipment with corresponding records, including planning for replacement

Guidance

This should include time to allow for planned preventative maintenance and a risk assessment of kit which isn't replaced.

Evidence requirements

- The service operational policy, including a section on
  - roles and responsibilities for reporting any kit or decontamination failure and management
  - safety monitoring, reporting and escalation.

10. Access and booking

C 10.1: There are standard operating procedures and roles to support waiting list management, booking and scheduling practices.

Guidance

Patients at risk of breaching waiting times should be identified, escalated and offered appropriate dates for admission.

JAG strongly recommends that referrals are pooled to support waiting times.

Evidence requirements

- The service operational policy, including a section on:
  - access for new patients
  - patient tracking list (PTL) management and validation (may be to an NHS contract)
  - booking and scheduling rules
  - vetting
  - pooling
  - surveillance management
  - operational meetings
  - escalation processes.
- The process for determining and monitoring the capacity of each endoscopy list.
- Details of progress for validating patients against the 2019 surveillance guidelines (if guidelines are not completely implemented).

C 10.2: There is an electronic scheduling system that facilitates efficient booking and scheduling as well as capacity planning.

Evidence requirements

- The service operational policy including a section on:
  - scheduling rules for all endoscopists, including points/cases expected per list
  - booking and scheduling processes
  - administrative pre-check for all patients.

C 10.3: There is a patient-centred booking system.

Guidance

This is defined as the patient having an informed choice of when to attend and given the opportunity to agree a date at the time of, or ideally within 72 hours of, the referral or decision to treat. It is expected that the service should reflect national and local recommended patient-centred booking practices.

Evidence requirements

- The service operational policy, including a section on patient-centred booking for new and surveillance patients.

B 10.4: All appropriately vetted inpatient procedures are performed within two working days.

Guidance

This does not usually apply if the service does not have an inpatient service.

Inpatients should be afforded a timely and appropriate, high-quality endoscopy service. The timescales allow for the preparation of patients for urgent colonoscopy. Patients may not need the procedure in this timescale and could be discharged to have it as an outpatient.

Evidence requirements

- The service operational policy including:
  - vetting practices for inpatient procedures
  - demand and activity data for inpatients
  - tracking of 48-hour timescales.

B 10.5: The service adheres to waiting time criteria for routine, surveillance and urgent cancer procedures.

Guidance

Systems should be able to produce up-to-date waiting list and surveillance information. It is appreciated that many independent hospitals do not have waiting lists and offer immediate access; however, there will still be a record or summary list of patients waiting to come in.

Evidence requirements

- Endoscopy waiting list information and surveillance data for the service for the previous 3 months (use mandatory template 3). See the JAG waiting times template for the latest waiting times targets and tolerances.
- If the service is not meeting waiting times due to COVID-19:
  - details of changes to vetting and validation practices to reduce unnecessary referrals
  - detailed recovery plan with expected timescales.

B 10.6: Monitoring of outsourced patients is undertaken as per national guidance. There are policies and processes to commission and operationalise insourcing and outsourcing providers.

Guidance

Refer to the JAG insourcing and outsourcing guidance

Evidence requirements

- Details of any insourcing arrangements, including completed insourcing checklist (2019).
- Details of any outsourcing arrangements, including completed outsourcing checklist (2020). Special attention must be paid to any outsourcing to a non-accredited provider and risk assessment.

A 10.7: All appropriately vetted urgent upper GI and ERCP inpatient procedures are performed within 24 hours and colonoscopy within 48 hours.

11. Productivity

C 11.1: Service productivity metrics are documented in the operational policy and are reviewed and acted upon.

Guidance

The service should consider including as a minimum the following performance and productivity dataset:

- overall/individual utilisation of lists
- booked versus achieved points for each list
- start and finish times audit
- room turnaround audit
- did not attend (DNA) and cancellation rates.

Evidence requirements

- Summary of the service delivery model (eg hot/cold sites, three session days or weekend working)
- The service operational policy that contains sections on:
  - the productivity metrics for the service including performance and productivity data (overall/individual utilisation of lists, start and finish times audit, room turnaround audit, DNA and cancellation rates)
  - analysis of productivity results and recommendations discussed at EUG meeting.

B 11.2: There is a regular review of demand, capacity and scheduling with key service leads.

Guidance

Service teams need accurate demand and capacity information to deliver and plan services effectively.

The frequency of unfilled lists should be reviewed. There should be active backfilling of lists and flexibility in endoscopist job plans to enable this.

In the non-acute sector continuity of service provision is important. Available lists may be offered to other consultants.

Evidence requirements

- Demand and capacity data/report, with plans to address any shortfalls in demand and capacity, eg business plan.
- If the service is insourcing details of all insourcing arrangements.
- If the service is outsourcing to another provider; the name of the provider.

C 11.3: The service offers an administrative pre-check to identify issues and to avoid cancellations.

Guidance

This ensures that the service has the up-to-date information about the patient's condition and medications. It could include a telephone assessment and may be undertaken by administration staff and supported by practitioners, or led by practitioners.

Evidence requirements

- The service operational policy for:
  - process for administrative pre-checks and
  - telephone pre-assessment and/or face to face pre-assessment.

B 11.4: There is an annual planning and productivity report for the service with an action plan.

Guidance

See 11.1.

Evidence requirements

- Capacity plan/model to meet growth in demand or change in service.

12. Aftercare

C 12.1: There are procedure-specific aftercare patient information leaflets for all procedures performed.

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Evidence requirements

- A summary list of all aftercare information with dates of review.
- Three examples of patient aftercare information, ideally colonoscopy and gastroscopy.
- Examples of health and ongoing care information.

C 12.2: There is a 24-hour helpline for patients or carers who have questions or experience problems, and the contact is aware of the protocol to advise and manage patients.

Guidance

The contact number might be staffed by nursing staff on a gastroenterology ward; nursing staff on an endoscopy on-call rota; or in another department and A&E (if it has been agreed beforehand).

A call-back system is a suitable alternative whereby the patient calls the switchboard and is called back by a member of the endoscopy team.

Evidence requirements

- A service operational policy that includes a section on aftercare including:
  - A process to support patients who need help (a 24-hour contact number for patients). This may be an internal service or one that has been agreed with another provider.
  - Patients should be informed of the helpline/ number on discharge.
  - How patients are informed of the procedure outcome and next steps, eg pathology results.

The above evidence should show how practice has been risk assessed and modified to consider infection control in light of COVID-19.

C 12.3: Patients are informed if they are suspected of having a malignancy on the same day as the procedure unless considered to be in the patient's best interest not to do so. This should be documented.

Guidance

See 6.6.

Evidence requirements

- A service operational policy that includes a section on aftercare including:
  - the process for informing patients of having a malignancy and support.

B 12.4: Patients and carers are told the outcome of the procedure and ongoing care, accompanied with a copy of the endoscopy report (or a patient-centred version).

Guidance

Patients may be advised that they will be followed up or to return to their GP. If inappropriate to provide a copy of the report, the reason is recorded.

Evidence requirements

- A service operational policy that includes a section on aftercare including:
  - reports for patients and how they are given (refer to CQ 6.1 for process on printing)
  - how patients are informed of the procedure outcome and next steps, eg pathology results.

13. Patient involvement

C **13.1: Patients and carers can give feedback in a variety of formats (such as focus groups, patient forums, questionnaires and invited comments) and in confidence.**

Guidance

This could include verbal, written and web-based feedback. Services should consider several approaches including questionnaires, social media or invited comments. Services should consider how the needs of diverse communities are met.

Evidence requirements

- Patient involvement strategy for endoscopy (ie involvement in review of patient materials, patient pathway, patient stories and EUG).
- Methods of regular feedback in addition to an annual survey (eg patient and family friends test card).

C **13.2: Complaints are reported, investigated and recorded. Findings are disseminated to relevant parties and acted upon.**

Guidance

The complaints procedure should be available for patients and carers to access.

Evidence requirements

- Summary of patient complaints, recommendations, shared learning and outcomes in the past year.

C **13.3: Patient feedback and agreed actions are disseminated and discussed at EUG (or equivalent) and practitioner meetings to ensure learning.**

Evidence requirements

- Minutes to show that the outcomes from the annual patient survey or other more frequent surveys have been discussed with actions planned where required. Smaller surveys conducted more frequently are acceptable.

B 13.4: The service conducts a patient feedback survey on patients' experiences in endoscopy at least annually. Actions are reviewed to ensure they are resolved.

Guidance

This is separate to the 'family and friends' test.

The patient survey should be sent to at least 5% of your patients who have undergone endoscopic procedures.

See 13.2.

Evidence requirements

- Results from the patient survey in summary form, which includes patients who received care from insourcing or outsourcing providers.

B 13.5: An executive summary of patient feedback and details of changes made in response are displayed in the service.

Guidance

This could be a 'you said, we did' board.

Evidence requirements

- Evidence of the executive summary and details of where this is displayed.

B 13.6: Patients participate in developing and evaluating services.

Guidance

This should define how patients are involved in the service, particularly its development and review of patient related activities including:

- Patient information and website
- Endoscopy user group
- Patient interviews
- Review of patient feedback

Evidence requirements

- Patient involvement strategy and plan
- Examples of achievements/improvements

14. Teamwork

C 14.1: There is a document outlining the ethos, culture, professionalism responsibilities and discipline of the team, which is reviewed annually.

Guidance

The document should also describe the mission statement and objectives of the team. It should include a summary of what inclusivity means and how diversity is recognised and celebrated. This includes visiting or temporary staff, eg agency staff, insourcing teams and staff who support the service or undertake only part of the patient journey.

Evidence requirements

- Documented guidance or a statement, outlining the ethos, culture, professionalism and discipline of how the team works together.
- Description of the members of the team, and the responsibilities of both the core and wider team (operational or workforce policy or other document).

C 14.2: A matrix of staff competencies for all procedures undertaken is visible within the service.

Guidance

The matrix should include all endoscopist and supporting clinical staff competencies within the service.

Evidence requirements

- Matrix of staff competencies for all procedures undertaken.

C 14.3: All staff are involved in the development of the service and are aware of how this affects their roles and practice.

Guidance

The matrix should include all endoscopist and supporting clinical staff competencies within the service.

Evidence requirements

- Two sets of minutes each from admin, nursing and EUG meetings (and any other relevant groups).
- Examples of project work, published papers or research work participated in.

C 14.4: There are structured handovers for briefing and debriefing at each list to ensure safe efficient practices during lists and effective learning.

Guidance

See 2.5.

Evidence requirements

- Example of safety checklists and assessment process (WHO checklists, pre-procedure brief and debriefs).
- Examples of risk management, assessments, incident reporting, staff awareness.

B 14.5: The endoscopy team and service users are surveyed at least annually on their perceptions of service delivery and improvements. Learning is actioned and reviewed every 6 months to ensure progress.

Evidence requirements

- Local survey of the endoscopy team (which includes all staff) and service users about their perceptions on patient care, team leadership, team working, and communication with patients and other professionals, and for how the service could be improved. This should be specific to the service and not hospital-wide. For smaller services a team meeting discussing and noting feedback is acceptable.
- Feedback in various forms from endoscopy users of the service, eg wards and GP referrers.
- Minutes that show the staff survey has been discussed and actions planned if required.
- Quality improvement plans.

The above evidence should consider the effect of COVID-19 on staff wellbeing and staff absence, including an action plan with timescales where appropriate.

B 14.6: There are processes to recognise and reward excellent performance within the team.

Guidance

The organisation should determine methods for reward, for example outstanding service awards.

Evidence requirements

- Examples of where teams and individuals have been acknowledged and rewarded for their performance (eg external training, conferences etc.).

A 14.7: The team meets annually to review processes and opportunities for quality improvement, networking with other teams regionally and nationally to share best practice and resolve service challenges.

Guidance

Networking may be undertaken by visiting other services, regional groups, speaking at meetings etc. The core clinical, nursing, administrative and managerial team take at least 1 day out together from normal service to undertake the review separate to the EUG or governance meeting.

15. Workforce delivery

C 15.1: Policies and systems ensure that there are sufficient competent staff with an appropriate mix of skills to allow rostering of staff to support the duration of the service activity.

Guidance

This should include a process describing staffing allocation for each list, including risk management of substantive and non-substantive staff. There should be a policy and escalation process for patient activity if staffing and skill mix do not meet the established agreed levels. Allocation of the workforce must support the expected duration of all service activity, eg inpatient activity, safety checks, handover etc.

Evidence requirements

- Summary of skill mix needs for the service for all staff groups (including decontamination staff when decontamination is managed by the service).
- The operational or workforce policy for the service that includes sections on:
  - recruitment and selection of staff
  - induction and training
  - mandatory training requirements
  - an example of the duty roster showing how service needs are met
  - how temporary staff, eg bank and agency are used.
  - annual skill mix review
  - sickness and absence rates
  - workforce development plans in anticipation of future demands in the volume and type of future demand, for the next year.
- Examples of endoscopy list schedules and rosters that identify where bank and agency staff have been used to support numbers.

C 15.2: A workforce skill mix review and an impact assessment of any deficiencies in service delivery is completed at least annually. An action plan to address is written and acted upon.

Guidance

This includes the management, medical, nursing, decontamination and administrative team members.

Evidence requirements

- A summary of annual workforce and skill mix review and needs for the service, including the administrative team and any planned appointments to support new work.
- Meeting minutes or action plans that show how deficits and impact on the service will be addressed.

B 15.3: There is a process to undertake staff recruitment in a timely manner so that the running of the service is not adversely affected.

Evidence requirements

- An operational or workforce policy for the service that includes sections on recruitment, selection and safety checks of staff including locums or other temporary staff members.

B 15.4: An induction programme and training needs analysis that meets the individual requirements of new staff is implemented and modified based on staff appraisal and feedback.

Guidance

The induction programme should help the staff member to understand their role and the team's, to welcome them to the team and to minimise disruption to the service.

This includes all visiting staff, such as locums, and non-substantive staff, such as agency staff, staff from other areas and insourcing teams.

Evidence requirements

- Induction and orientation pack based on endoscopy competencies and adapted to staff groups as required.
- Competency assessments for different grades of staff (including staff working in decontamination and out-of-hours services, ie theatre staff).
- Training needs analysis for substantive staff.
- Examples of clinical service specific education.
- Mandatory training schedule and compliance.

B 15.5: Workforce development plans anticipate the volume and type of future demand, for the next 2–5 years.

Evidence requirements

- Workforce development plans or business case.

B 15.6: The service leadership team promotes the health and wellbeing of staff members.

Evidence requirements

- Operational policy including section on support of team members.
- Examples of how this is delivered (this may be discussed at assessment).

A 15.7: There is a process for the recruitment and induction of senior staff which allows a handover period.

Guidance

There should be processes and escalation to provide continuity of service without safety or quality being compromised.

16. Professional development

C **16.1: There is a nominated training lead for the workforce with polices and systems that ensure the workforce is appropriately trained and competent, including any additional service-specific education and training.**

Guidance

The training should cover medical, nursing and administrative workforces. JAG strongly recommends the use of JETS Workforce to support competency development and training.

Evidence requirements

- A workforce, operational or organisational policy that describes:
  - appraisals and staff development
  - managing and supporting performance.

C **16.2: All healthcare professionals involved in delivering direct patient care have demonstrable competencies relevant to their role.**

Guidance

The wider team may include day surgery assessment and recovery staff, out-of-hours theatre teams and ward staff where recovery is undertaken. This should include assessment and updates of temporary staff, outsourcing service-level agreements, training needs analysis and self-disclosure for all clinical and administrative staff.

Evidence requirements

- A workforce list summary summarising:
  - who provides mentorship to newly appointed staff and students
  - a description of the processes for competency assessment
  - number of students, stage of training and level of support required.

C **16.3: A nominated mentor/trainer observes and supervises staff members until identified competencies have been achieved to demonstrate safe, independent practice.**

Guidance

The nominated trainer should have nationally agreed proficiencies, eg mentor course / Training the Trainer (TTT). There should be competency sign off at each stage of their development and final sign off. This should follow nationally agreed training profiles. This applies to medical and nursing staff, industry representatives, and professional and lay observers.

Evidence requirements

- A workforce list summarising who:
  - provides preceptorships and mentorships to new registered staff, existing staff and healthcare assistants (HCAs)
  - provides training or teaching and assessing skills.
- An operational, workforce policy or other training policy that covers the supervision of students, trainees and observers within the service.
- A list of staff with training and assessment qualifications and evidence of their maintenance.

C 16.4: There is an effective appraisal system for all staff, identifying learning needs and objectives. Additional learning should support revalidation requirements.

Guidance

Appraisal should include other relevant information such as patient and staff complaints, 360 feedback and training needs analysis. There should be feedback mechanisms to provide medical and nursing staff with evidence to support the revalidation cycle, eg 360-degree appraisal, KPIs, training needs review.

Evidence requirements

- A workforce summary of completed appraisals dates and personal development plans (PDPs).

This may be observed on the organisation's IT systems during the site assessment and should include administrative and decontamination staff (where managed by the service).

C 16.5: Staff have sufficient time and resource to meet their learning needs, including when new or replacement equipment is introduced.

Guidance

There should be a needs analysis which includes external providers to support learning opportunities.

Where the service requires specific learning to be undertaken, eg new starters, new procedural skills etc., this should be identified in job plans with outcomes and support required.

Revalidation requirements should be identified and resourced within annual appraisals. Where new processes or equipment is introduced, there should be a training plan with identification of competencies met for all the workforce, eg change in ERS.

Evidence requirements

- A summary of methods of training to support professional development.
- A summary of training needs and resources for the workforce.
- A named training lead to plan and facilitate the training timetable.

B 16.6: Processes address performance issues through the service leads

Guidance

All professionals should be provided with individual performance data sufficient to reliably inform their appraisal and revalidation requirements.

Evidence requirements

- The operational policy and process including a section on supporting staff performance and escalation processes.
- Evidence of application of the process (if applied) and outcomes.

B 16.7: Appraisal and training needs analysis allow the service to identify ways of providing professional development such as joint learning events, external training or providing accredited endoscopy-specific courses.

A 16.8: Educational facilitators are attached to the team and support learning and development.

Guidance

Examples of these are a professional development practitioner or clinical facilitator, for example JETS Workforce.

B

16.9: Service to demonstrate 10% (to increase to 25% in Oct 2025) of all healthcare professionals involved in the endoscopy patient pathway and assisting endoscopy procedures have completed the JETS Workforce programme ENDO1 training course, including the pre-course requisite e-learning for health ENDO1 modules.

Guidance

The training will include the completion of the ENDO1 e-learning for health modules and the ENDO1 course. Found on the JETS Workforce website. This excludes, administrators, doctors etc.

Evidence requirements

- This evidence will be a requirement from 1 October 2024. For training courses only, 25 % will be required by 1 Oct 2025
- A copy of the e-learning certificate should be provided before booking an ENDO1 course.
- Information will be pulled from JETS workforce to inform % for each registered service

A

16.10: Service to demonstrate 10% of all healthcare professionals, involved in the endoscopy patient pathway and assisting endoscopy procedures have completed the JETS Workforce foundation level competency framework.

Guidance

Refer to guidance in standard 16.9 in addition, services would need to have 10 % of staff completing the competency framework

17. Environment, training, opportunity and resources

C 17.1: Trainers and trainees use the JETS e-portfolio (or equivalent in ROI) to support training and evaluation.

Guidance

The JETS e-portfolio enables the local training lead to plan and monitor the training lists provided in the unit.

Evidence requirements

- Evidence from a JETS export /timetables showing training lists.

C 17.2: Training lists are available which are coordinated by a dedicated member of staff

Guidance

This should include details of, organisation of local training and training lead.

Evidence requirements

- A training policy covering:
  - details of key endoscopy staff and contact numbers
  - local induction process
  - appraisals
  - organisation of local training
  - training lead, including responsibilities, allocated time
  - JAG certification requirements and rules for independent practice
  - other useful training information and simulation resources
  - supervision outside of the endoscopy service.

C 17.3: There is an endoscopy induction programme for all new endoscopy trainees which references all key quality indicators. This is reviewed and updated annually.

Guidance

See e-Learning for Healthcare for endoscopy induction e-learning.

Evidence requirements

- A formal induction programme for trainees.
- Evidence of application of the above in practice (interviews with trainees on the visit day).

C 17.4: Feedback is obtained from endoscopy trainees on the availability of training support and the quality of the training environment.

Guidance

The JETS e-portfolio supports trainee feedback on the quality of the training received on any training list.

Evidence requirements

- Minutes to show training has been discussed to optimise opportunities for trainees.

B 17.5: There are processes to maximise endoscopy trainees exposure to emergency and urgent endoscopic procedures.

Guidance

Trainees identified as 'training in gastrointestinal haemostasis' will require evidence in JETS of an agreed local mechanism to maximise exposure to gastrointestinal bleeding.

Evidence requirements

- Process that ensures endoscopy trainees' exposure to emergency and urgent endoscopic procedures detailed within training policy.

B 17.6: The delivery of endoscopy training is reviewed in EUG or governance meetings which include trainee representation.

Guidance

Feedback should be gained from relevant areas (such as JETS and an annual training survey) and an improvement plan created where appropriate.

Evidence requirements

- Minutes to show training has been discussed to optimise opportunities for trainees.

B 17.7: Endoscopy trainees have at least 20 dedicated training lists annually which are planned at least 6 weeks in advance in addition to ad hoc training opportunities.

Guidance

A dedicated training list is defined as 'a pre-planned list, adjusted to a trainee's learning needs and supervised by an appropriately trained endoscopy trainer'.

Ad hoc training lists can add valuable additional training experience. The minimum number of 20 dedicated lists has been agreed by JAG, and medical and surgical specialist advisory committees (SACs) as realistic and deliverable.

Evidence requirements

- Training list allocation and schedule including ad hoc and dedicated lists (at an annual rate of at least 20 lists per year).

18. Trainer allocation and skills

C **18.1: There is a nominated trainer for each endoscopy trainee.**

Guidance

A description of the role of a local endoscopy training lead and requirements for sessional time to support the role is available on the JAG website.

Evidence requirements

- A list of trainers who have undertaken a Training the Trainers: (RCP – TTT, TCT, TGT or RCS TTT) course and can show evidence of maintaining and updating trainer skills relevant to the procedures for which they act as a trainer within the 5-year revalidation cycle.

C **18.2: A nominated local training lead has overall responsibility for ensuring the induction and appraisal of trainees (with recognised time in their job plan.**

Evidence requirements

- A summary description of the training lead role and responsibilities for the service including the time commitment allowed to support training leadership.

C **18.3: The local training lead has attended a JAG-approved TTT course and has maintained and updated trainer skills relevant to the procedures for which they act as a trainer.**

Guidance

JAG-approved TTT courses include generic endoscopy trainer courses or procedure-specific courses – it is not expected that a full TTT course needs to be repeated every revalidation cycle. Maintenance of training skill can be evidenced by satisfactory trainee feedback. Updating of trainer skills can be via any of the following:

- acting as faculty trainer on a JAG-approved course
- attending an additional procedure-specific TTT course
- enrolment on a formal medical education course (PCME, Diploma, MSc, PhD).

Evidence requirements

- Training lead participation as a trainer in a JAG approved training course within the 5-year revalidation cycle.

C 18.4: Endoscopy trainers' performance is reviewed and actions taken to develop trainers.

Guidance

This should include a review of trainee feedback and audited KPIs with the local training lead, and may include an action plan for improvement.

JETS will be examined with trainers during the site assessment.

Evidence requirements

- Minutes where KPI data has been reviewed, demonstrating that the training lead regularly reviews BSG quality and safety indicators for all endoscopy trainers.
- Evidence of feedback and discussion (eg minutes where trainers have been reviewed and other communication such as emails to trainers with action points).

C 18.5: All trainers supervising dedicated training lists are registered on JETS, have attended (or are supported to attend) a TTT course and have maintained and updated trainer skills relevant to the procedures for which they act as a trainer.

Guidance

All trainers should maintain and develop their training skills. Examples of this include:

- participation in and JETS feedback from faculty involvement on a JAG-approved endoscopy training course.
- a TTT/TET/TCT/TGT style course performed within the revalidation cycle.
- a formal medical education qualification, eg PCME, Diploma or MSc level course.
- deanery-related trainer skills course that may be transferable to endoscopy practice (CPD approved).

Evidence requirements

- Minutes where trainer performance is reviewed including faculty attendance at external courses.
- Trainer feedback for all trainers (eg direct observation of trainer skills (DOTS) on the JETS website).

A **18.6: There is an annual direct observation of training skills assessment for all endoscopy trainers (based on Direct Observation of trainer skills (DOTS) and long-term endoscopy trainer skills (LETS) assessment tools).**

Guidance

DOTS and LETS tools are available via the JETS e-portfolio.

A **18.7: At least one trainer participates as training faculty on a JAG-approved training course annually.**

Guidance

Training leads should provide recommendations to JAG regional training centre leads to support the development of individual trainers and augment regional training faculty.

19. Assessment and appraisal

C **19.1: All endoscopy trainees have completed a mandatory JAG basic skills courses or have a course booked.**

Evidence requirements

> Evidence that all endoscopy trainees have completd or booked a basic skills course.

C **19.2: All endoscopy trainee activity is recorded.**

Evidence requirements

> Evidence that all endoscopy trainee activity is recorded on JETS.

C **19.3: There is an appraisal completed (for example, in the JETS e-portfolio) for all trainees commencing their training to identify their learning needs.**

Evidence requirements

> Evidence of endoscopy trainee appraisals completed in the JETS e-portfolio.

C **19.4: There is an assessment of endoscopic skills conducted by the local training lead (or nominated deputy) for trainees seeking to perform procedures independently.**

Guidance

The JETS e-portfolio uses the Direct Observation of Procedure or Skills (DOPS) as the main trainee assessment tool. These can be completed during a training list and learning objectives can be set, which populate the trainee's personal development plan.

Evidence requirements

> Evidence of summative DOPS required for the JAG certification process.

C 19.5: There is a policy for defining and monitoring independent practice of endoscopy trainees.

Guidance

The JETS e-portfolio documents progression of training and is transferable between services. This allows for review of training goals and is important for continuity of training and maintenance of training standards.

Evidence requirements

- Policy for defining and monitoring independent practice of endoscopy trainees.

C 19.6: There is a visible updated register within each procedure room of trainees allowed to perform specified procedures independently.

Evidence requirements

- In-room competency register identifying trainees, training modality, and current level of supervision.

B 19.7: Endoscopy trainees have an appraisal with their trainer (for UK trainees, this should be completed on the JETS e-portfolio) at least annually.

Evidence requirements

- Evidence of trainee appraisal.

A 19.8: The local training lead regularly reviews the number and quality of DOPS and/or LETS assessments performed by trainers to ensure supportive training.

Guidance

It is recommended that this standard is incorporated into an annual endoscopy training review (ETR).

19. Assessment and appraisal

A **19.9:** Intermediate appraisal is undertaken at least every 6 months (appropriate to the duration of a trainee's attachment) with adjustment of training goals.

A **19.10:** Training lists are actively modified and action plans documented on direct observation of procedural skills (DOPS) assessments in response to the training needs

Please speak to your endoscopist for more information or contact

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Royal College of Physicians

JAG Joint Advisory Group on GI Endoscopy