JAG - Paediatric Global Rating Scale (GRS) census
Frequently asked questions

What is the Global Rating Scale census?
The Global Rating Scale (GRS) is a quality improvement tool which has been adopted by adult endoscopy services. It has proven to be effective in supporting improvement in standards and the quality of care offered to patients in adult endoscopy services.

The paediatric GRS has been adapted from the established adult framework. The Royal College of Physicians of London (RCP) and the British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN) have collaborated to ensure the standards are relevant and appropriate for the paediatric setting.

The GRS is made up of 19 standards. These standards are divided into four domains. Each standard has a number of measures which underpin it. Each measure is assigned a level from D to A (scoring is explained in the 'Levels' section below). Services are asked to answer 'yes' or 'no' to each measure using the webtool which can be accessed at https://www.thejag.org.uk/. The measure answers then generate a score for the service for each standard.

Domain
Each domain refers to a broad aspect of care. There are four domains: clinical quality (quality and safety), quality of patient experience (customer care), workforce and training. All services are asked to complete the clinical quality, quality of patient experience and workforce domains. Only those offering endoscopy training are required to complete the training domain.

Standards
The standards within each domain provide a more detailed picture of what the domain consists of. The standards are qualitatively different and therefore no standard is more or less important than another.

Measures
Measures are statements that are intended to be unambiguous. In other words, a service has either achieved them or it has not. To assist services in answering appropriately, guidance statements have been added where necessary.

GRS domains and standards	
Clinical quality	**Quality of the patient experience**
1. Leadership and organisation 2. Safety 3. Comfort 4. Quality 5. Appropriateness 6. Results	7. Respect and dignity 8. Consent process including patient information 9. Patient environment and equipment 10. Access and booking 11. Planning and productivity 12. Aftercare 13. Patient involvement
Workforce	**Training of endoscopists***
14. Teamwork 15. Workforce delivery 16. Professional development	17. Environment, training, opportunity and resources 18. Trainer allocation and skills 19. Assessment and appraisal

Levels
Levels begin to create a more complete picture of what is going on by describing the different levels of achievement for a standard. These levels range from basic (D) to aspirationall (A). While scoring a standard with levels gives an accurate picture of what is going on, the scoring process can be subject to bias. To minimise bias, where appropriate, measures are underpinned by national policy, guidelines and/or best practice guidance.

Services are required to score a Level B in all standards in order to apply for and, once achieved, to maintain JAG accreditation.

Level	Summary	Description
A	Aspirational	service is 'outward looking' with excellent adherence to requirements
B	Audit	service is proactive to changes with a good adherence to requirements
C	Process	service is reactive to changes with basic adherence to requirements
D	Policy	service shows generally inadequate levels of adherence to requirements

*Training of endoscopists only needs to be completed by services offering training.

How long will the scale take to complete?
The scale will take approximately 1-2 hours to discuss with your team and agree the responses to the measures. It will then take a member of staff approximately 30 minutes to input the answers onto the online system. It will take longer to complete on the first attempt.

It is recommended that you print out the document and discuss with your team prior to submission.

What is the deadline for completion of this national census?
Services are given 1 month to complete the census. The deadline for completion of the October census is 31 October. GRS submissions need to be completed in a timely fashion to allow for national reporting to be completed.

When can we view our data?
All units may view their GRS results as soon as they have submitted their monthly or biannual return. However, to compare your data against regional and national averages, this will only be possible after the national results have been released.

Who should be involved in the completion of the scale?
It is recommended that the whole team has an opportunity to both discuss and contribute to the completion of the GRS. The following members of staff are key to this process:

- the nurse lead
- the clinical lead
- the operational manager for the unit

Why is in important for nurse lead, the clinical lead and the operational manager for the unit to be involved in the discussions?
It is important to have a cross-section of professional groups involved in completing the scale to get an accurate assessment of the challenges facing the service. This will ensure full engagement and ownership by the team. Action plans are more likely to be supported if the scale is approached in this way.

Will my scores be anonymised?
The intention is that **only** you and the JAG will be able to identify your scores. However, the Freedom of Information Act states that we will be obliged to release information if requested to do so. Having said this, we will do our best to maintain anonymity.

Is this not just another set of Government targets?
We would prefer to use the term 'aspirational goals' rather than targets. Health professionals working in the service have chosen the items and the measures that underpin the levels.

Can I use this scale to help me get more resource for my unit?
If the GRS identifies that a unit could do much better for certain parts of your service, it would be expected that hospital management ask whether there was anything to be done within your current resource to improve the situation and to support necessary improvements so that the standards are attained.

We haven't got an IT system that can provide us with data for the clinical outcomes. Do we need one?
It will be very difficult to achieve the highest scores on quality, safety, aftercare and comfort without a modern endoscopy reporting system. If you haven't a system, or your current one cannot provide the data, we strongly recommend you place an early bid for such a system.

The highest scores on the scale seem unobtainable because we are fire fighting all the time. Is it realistic to expect to achieve them?
We have tried to ensure that there is nothing unachievable on the scale. The level A measures are aspirational and should be treated as such. For adult services level B is the standard for accreditation.

How does the scale support service improvement?
Our starting point when we devised the scale was to ask the question: what matters to the patient? We believe service improvement is all about making it better for the patient and the GRS is all about identifying the gaps in patient care. Once you now where the gaps are and how big they are you can start prioritising your efforts to improve the service.

How do I search for help with a measure or item?
Most measures have a guidance note that provides additional information on the measure and how to answer it. Some measures also have a document linked to them.

How do I give feedback on an article or on any other part of the system?
Your feedback is important to us and will be regularly reviewed by the national steering group. If you have suggestions and ideas for improvements please feel free to tell us.