Royal College of Physicians | JAG Joint Advisory Group on GI Endoscopy

JAG accreditation

Global rating scale (GRS) for UK services

2021 version

This version of the 2021 GRS is designed for the consultation with JAG leads, assessors and stakeholders. It is in draft and will be replaced by a formal, published version.

It should not be shared without permission from the JAG office.

Introduction

The Global Rating Scale for Endoscopy (GRS) 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. The standards are 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

Suggested evidence which should be uploaded by services for the purposes of accreditation is listed. 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.

No	Measure	Lvl	Guidance	Evidence requirements
1. Leadership and organisation				
1.1	There is a defined leadership and governance structure with clinical, nursing and managerial lead roles, with protected time in their job plans.	C	The leadership team should invite staff feedback to assess their effectiveness, for example a 360 feedback process.	• 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
1.2	Clear information is available about the range of endoscopy procedures provided at this and all associated sites.	C	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 stand-alone service or operates on multiple sites, whether patients may be referred to other organisations, and any outsourcing and insourcing arrangements.	• 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 users (see 14.5)

1.3	There are defined operational, nursing and governance meetings within the service that support organisation and delivery.	C	The 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.	• 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 (endoscopy users group (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).

1.4	There are processes and timescales to review and maintain all policies and standard operating procedures.	C	This might be a hospital document management system or locally devised system. Owners and review dates should be recorded on all key documents.	• Evidence of a system of document management including owners and dates of review for all key documents.
1.5	There is an annual audit plan for the service with named leads and timescales.		See the JAG quality and safety guidance.	• Annual rolling audit plan including named leads and timescales (this should include clinical and other audits ie patient and staff).
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.	B	This includes a NED compliant endoscopy reporting system and other data capture systems for productivity.	• Summary of managerial, administrative and technical support for the service and key functions.

1.7	The leadership team review and plan how to meet the service's strategic objectives annually, including for any service developments.	B	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.	• 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).
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.	B	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.	• Examples of innovation, sharing of quality improvements or research
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, such as reducing plastic waste.	A	The service should reflect hospital objectives to improve environmental impacts.	

2. Safety				
2.1	Adverse events and key safety indicators are recorded, monitored and acted upon.	C	Services should use their organisation-wide adverse events management system to show how near misses and adverse events are managed and learned from. The BSG outcomes that require monitoring are described in the JAG quality and safety guidance.	• 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.
2.2	A pre- and post-procedure safety checklist is used for each endoscopy list.	C	See the WHO safe surgery checklist.	• Example use of validated safety checklist (eg WHO safety checklist).
2.3	Patient's fitness for oral bowel cleansing agents is assessed and documented prior to bowel preparation being dispensed.	C	See the ESGE guidelines.	• Bowel preparation and dispensing policy
2.3	The leadership team review adverse events at least every 3 months. This is shared locally and nationally where appropriate.	C	Actions should be agreed & recorded at the endoscopy user group (EUG) meeting or other appropriate governance meeting. In smaller services this may be a joint meeting with another service (for example, theatres).	• 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.

2.4	There are core clinical protocols to support patient safety.	C	See the BSG website for clinical guidelines.	• The endoscopy clinical protocols for management of:
				  ○ diabetes
				  ○ anticoagulation including NOACs (novel oral anti-coagulants)
				  ○ anti-platelet agents
				  ○ antibiotic use in patients undergoing endoscopy
				  ○ implantable devices in patients undergoing endoscopy
				  ○ transnasal endoscopy (if performed)
				  ○ safe prescribing and distribution of oral bowel preparation
				  ○ Screening protocol for COVID-19

2.5	The endoscopist and nurses meet before each list to identify any potential risks or issues.	C	The focus of this should be to share safety learning and to identify potential patient, environment, kit, infection control and staffing issues.	• 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).
2.6	A lead clinician is responsible for local integrated care pathways for both upper and lower GI bleeding and their clinical governance.	C	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.	• A summary description of the leadership role and responsibilities for upper and lower GI bleeding.

2.7	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.	B	The National Institute for Health and Care Excellence (NICE) has an acute upper gastrointestinal bleeding in adults quality standard. See the BSG acute upper GI bleed care bundle. See the NCEPOD report on GI bleeds.	• 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 gastrointestinal 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
2.8	There is a process for identifying, reviewing and reporting deaths and unplanned admissions related to endoscopy.	B	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.	• RCA of known deaths and unplanned admissions • Minutes demonstrating an annual review of mortality and morbidity in endoscopy

			Services should conduct a root case analysis of any cases that they are made aware of.	and that 'lessons learnt' are recorded and acted upon. • SOP for reporting of deaths and unplanned admission possible related to endoscopy and how they are then reviewed

3. Comfort				
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)	C	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.	• The policy and process for patient comfort, monitoring and reporting in endoscopy. This can be included as part of the operational policy.
3.2	Nurses monitor and record patient pain and comfort levels during and after the procedure using a validated scoring scale.	B	A comfort assessment should cover all endoscopy procedures, irrespective of sedation level. It is the endoscopy nurse'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 nurse is the best judge of the level of discomfort. Sedation may also affect patients' perception of discomfort. The nurse and endoscopist should agree the score before the end of the procedure and the endoscopist enter this on the ERS.	• 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 nurse and patient reported levels are included in patient comfort monitoring and reporting.
3.3	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.	B	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.	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 (see JAG guidance on managing endoscopist underperformance).
3.4	The service is able to use CO_2 insufflation and provide N_2O inhalation for patients undergoing GI procedures	A		
3.5	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.	A	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				
4.1	Individual endoscopists are given feedback on their procedure KPIs at least twice per year.	C	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.	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).
4.2	Individual endoscopists are given feedback on their safety outcomes at least annually.	C	The specific BSG safety outcomes that require review are described in the JAG quality and safety guidance.	• Evidence that individual endoscopists are given feedback on their safety outcomes at least annually eg PCCRC • Minutes that show that any post-colonoscopy colorectal cancers (PCCRC) that have arisen in the service (cancer diagnosed within three years after a colonoscopy has been performed) have a root-cause analysis with action planned as required. • Operational policy which describes how PCCRCs are identified and acted upon.

4.3	If individual endoscopist performance levels are not achieved the service manages underperformance according to national guidance.	C	See JAG guidance on managing endoscopist underperformance).	• 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.
4.4	An endoscopy reporting system (ERS) captures immediate procedural and performance data. The ERS uploads all GI endoscopy procedures to: UK: the National Endoscopy Database (NED). ROI: the National Quality Assurance Improvement System (NQAIS).	B	This includes cases outside endoscopy unit, such as emergency procedures, ERCPs performed in radiology and paediatric patients. See the NED website.	• No evidence required - JAG will check whether the service is compliant with this standard prior to booking an assessment.
4.5	The service collects data for inpatients who undergo endoscopy, including indication, waiting times, and relevant auditable outcomes.	B	This does not usually apply if the service does not have an inpatient service.	• Report showing service waiting times for inpatients and outcomes for inpatients that undergo endoscopy. • EUG minutes showing evidence of agreed action plans.
4.6	The service collects details of all 'off unit' GI endoscopy that occurs in the organisation and captures this on the ERS	B	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.	• The service operational policy including a section on ERS use and off unit endoscopy.

5. Appropriateness				

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

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.	C	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.
				• 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 IM.

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.	C	Non acute services completing NHS contracts should follow the agreed direct access criteria in any agreements.	• Service vetting SOP or section in operational policy. • Examples of NHS contracts with agreed direct access criteria.
5.4	Inpatient endoscopy requests are triaged daily to prioritise clinically urgent cases.	B	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.	• 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.
5.5	All surveillance procedures are clerically and clinically validated according to national guidance at least 2 months prior to the due date.	B	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).	• 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).
5.6	The vetting process is reviewed annually and action plans are created to address any issues.	B	Outcomes and action plans should be agreed at the endoscopy EUG	• Review or audit of effectiveness of vetting process and outcomes • EUG minutes and action plan.

6. Results				
6.1	Endoscopy reports for all inpatients are added to the patient record before the patient leaves the department.	C		• 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
6.2	There is a process for referring patients with a suspected or definitive cancer diagnosis to the multidisciplinary team (MDT).	C		• 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 nurses. • For the non-acute sector, the policy for referral to a local MDT team. • Policy for referral to a specialist nurse or competent other to provide support patients within 24 hours of their diagnosis.
6.3	There is a process for pathology, to track malignant histology and to ensure prompt referral for management and treatment.	B	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.	• SOP for specimen labelling, recording and reporting • Policy stating who is responsible to receive, review and act on histology results.
6.4	Endoscopy reports are completed on the day of the procedure and include follow-up details, and are sent to the	B	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,	• Process for producing/printing reports

	patient's GP and the referring clinician (if different) within 24 hours of the procedure.		however it is expected that a service will work towards this. JAG recommends that reports are sent electronically.	• If endoscopy is preformed outside the unit evidence that there is local access to the ERS to ensure timely reporting.
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.	B	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.	• The service operational policy including sections on: o who is responsible to receive, review and act on histology results. o the processes for reporting and timelines for pathology in endoscopy o the process for endoscopy reports to be sent to the patient's GP and also to the referring clinician o the process for annual leave cover and reviewing of pathology results.
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.	B	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.	• SOP to support patients with a cancer diagnosis

7. Respect and dignity				
7.1	There is a respect, dignity and security policy, which includes the care of adults and children accessing the service.	C	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.	• 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.
7.2	There is a safeguarding policy for adults and children within the department.	C	There should be a specific description of how vulnerable patients are cared for contained within the operational policy.	• The service operational policy, including a section on: ○ safeguarding adults and children (if applicable)

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

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)	C	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	• Link to service website with patient information and resources. • Example of patient information that reference patient's rights and expectations.
7.5	Staff are trained to act with discretion and respect towards all patients and carers.	C	Training for staff may be organisation wide or bespoke for the endoscopy service.	• Staff training and updates regarding respect and dignity, which includes equality and diversity.
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.	C	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.	• The service operational policy, including sections on: ○ The use of interpreters including the use of family members or carers

7.7	Patients' confidentiality, privacy and dignity is protected throughout the pathway.	B	The JAG environment guidance details measures to maintain confidentiality, privacy and dignity. Of particular importance is: - There 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.	● 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				
8.1	Patient information for all relevant procedures is given to patients ahead of the procedure (diagnostic and therapeutic).	C	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.	• 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
8.2	There is a policy for consent including withdrawal of consent during a procedure (whether awake or under conscious sedation).	C		• 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.
8.3	The requesting clinician documents a patient's fitness for oral bowel cleansing agents prior to dispensing bowel preparation.	C	It is essential to verify that their 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	• Evidence that the requesting clinician documents a patient's fitness for oral bowel cleansing agents prior to bowel preparation being dispensed.

			the accepting clinician to ensure that this happens.	
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 or any immediate waiting room. There are processes for those who cannot sign the form and the consent process is undertaken by a trained professional.	C		• See 8.2 • Policy and/or SOP for patients who cannot sign their consent form.
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.	C	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 therapeutic oesophagogastroduodenoscopy (OGD), percutaneous endoscopic gastrostomy (PEG),	• Policy and/or SOP for pre-assessment of high-risk patients attending for high-risk procedures.

			endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic mucosal resection (EMR).	
8.6	The consent process for inpatients is commenced on the ward, by a competent individual.	B	This does not usually apply if the service does not have an inpatient service.	• Policy and/or SOP for pre-assessment of inpatients and preparation for the procedure.
8.7	There is a process to review patient information annually to reflect patient feedback and changes in practice or risks.	B	This activity should be included in the EUG or equivelant.	• EUG meeting minutes or equivelant. • See 1.5
8.8	Appropriate patients are routinely pre-assessed, either by telephone or in person.	B	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.	• Policy and/or SOP for pre-assessment of patients.

9. Patient environment and equipment				

9.1	There is a description of the facilities available for patients and referrers.	C	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).	• 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.

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	C	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)	• 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.

9.3	The facilities and environment support service delivery	C	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	• 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)
9.4	There is an endoscopy management lead and decontamination user (manager) responsible for the endoscopy facility and environment management.	C	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.	• 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.

9.5	There is an annual review of equipment including endoscopes and a process for replacement.	C	This should include a risk assessment of kit if not replaced.	• 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
9.6	All areas are well-maintained and support efficient patient flow and ergonomic and efficient working. Access is restricted as appropriate.	B	See the JAG environment guidance. The patient pathway/facilities will be examined during the site assessment.	• SOP or operational policy for unit access and restrictions
9.7	Systems maintain and quality assure equipment with corresponding records, including planning for replacement.	B	This should include time to allow for planned preventative maintenance and a risk assessment of kit which isn't replaced.	• 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				

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

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

10.3	There is a patient-centred booking system.	C	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.	• The service operational policy, including a section on patient centred booking for new and surveillance patients.
10.4	All appropriately vetted inpatient procedures are performed within two working days.	B	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.	• The service operational policy including: o vetting practices for inpatient procedures o demand and activity data for inpatients o tracking of 48 hour timescales.
10.5	The service adheres to waiting time criteria for routine, surveillance and urgent cancer procedures.	B	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.	• 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 meet waiting times due to COVID-19: o Details of changes to vetting and validation practices to reduce unnecessary referrals o Detailed recovery plan with expected timescales.

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.	B	Refer to the JAG insourcing and outsourcing guidance	• 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.
10.7	All appropriately vetted urgent upper GI and ERCP inpatient procedures are performed within 24 hours and colonoscopy within 48 hours.	A		

11. Productivity				
11.1	Service productivity metrics are documented in the operational policy and are reviewed and acted upon.	C	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.	• 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.
11.2	There is a regular review of demand, capacity and scheduling with key service leads	C	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.	• Demand and capacity data/report, with plans to address any shortfalls in demand and capacity e.g 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.

11.3	The service offers an administrative pre-check to identify issues and to avoid cancellations.	C	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 nurses, or led by nurses.	• The service operational policy for:
				  ○ process for administrative pre checks and
				  ○ telephone pre assessment and/or face to face preassessment

11.4	There is an annual planning and productivity report for the service with an action plan.	B	See 11.1	• Capacity plan/model to meet growth in demand or change in service.

12. Aftercare				
12.1	There are procedure-specific aftercare patient information leaflets for all procedures performed.	C		• 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
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.	C	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 the 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.	• A service operational policy that includes a section on aftercare including: o a 24-hour contact number for patients o 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.
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.	C	See 6.6	• A service operational policy that includes a section on aftercare including: o the process for informing patients of having a malignancy and support

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).	B	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.	• 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				
13.1	Complaints are reported, investigated and recorded. Findings are disseminated to relevant parties and acted upon.	C	The complaints procedure should be available for patients and carers to access.	• An example or summary of patient complaints, recommendations, shared learning, and outcomes.
13.2	Patients and carers can give feedback in a variety of formats (such as focus groups, patient forums, questionnaires and invited comments) and in confidence.	C	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.	• 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).
13.3	Patient feedback and agreed actions are disseminated and discussed at Endoscopy User Group (EUG) or equivalent and nurse meetings to ensure learning.	C		• 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.

13.4	The service conducts a patient feedback survey on patients' experience in endoscopy at least annually. Actions are reviewed to ensure they are resolved.	B	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	• Results from the patient survey in summary form, which includes patients who received care from insourcing or outsourcing providers.
13.5	An executive summary of patient feedback and details of changes made in response are displayed in the service.	B	This could be a 'you said, we did' board.	• Evidence of the executive summary and details of where this is displayed.
13.6	Patients participate in planning and evaluating services.	A		

14. Teamwork				
14.1	There is a document outlining the ethos, culture, professionalism responsibilities and discipline of the team, which is reviewed annually.	C	The document should also describe the mission stattment 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.	• 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*).
14.2	A matrix of staff competencies for all procedures undertaken is visible within the service.	C	The matrix should include all endoscopist and supporting clinical staff competencies within the service.	• Matrix of staff competencies for all procedures undertaken.
14.3	All staff are involved in the development of the service and are aware of how this affects their roles and practice.	C		• 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.
14.4	There are structured handovers for briefing and debriefing at each list to ensure safe efficient practices during lists and effective learning.	C	See 2.5	• Example of safety checklists and assessment process (WHO checklists, pre-procedure brief and debriefs). • Examples of risk management, assessments, incident reporting, staff awareness.
14.5	The endoscopy team and service users are surveyed at least annually on their perceptions of	C		• Local survey of the endoscopy team (which includes all staff) and service users about their perceptions on patient care, team leadership,

	service delivery and improvements. Learning is actioned and reviewed every 6 months to ensure progress.			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.
14.6	There are processes to recognise and reward excellent performance within the team.	B	The organisation should determine methods for reward, for example outstanding service awards.	• Examples of where teams and individuals have been acknowledged and rewarded for their performance (eg external training, conferences etc.)
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.	A	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 one day out together from normal service to undertake the review separate to the EUG or governance meeting.	

15. Workforce delivery				
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.	C	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 skillmix 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.	• 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 & 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.
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.	C	This includes the management, medical, nursing, decontamination and administrative team members.	• 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.
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.	B		• 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.
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.	B	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.	• 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.
15.5	Workforce development plans anticipate the volume and type of future demand, for the next 2–5 years.	B		• Workforce development plans or business case.
15.6	The service leadership team promotes the health and wellbeing of staff members	B		• Operational policy including section on support of team members • Examples of how this is delivered (this may be discussed at assessment)

15.7	There is a process for the recruitment and induction of senior staff which allows a handover period.	A	There should be processes and escalation to provide continuity of service without safety or quality being compromised.	
16. Professional development				
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.	C	The training should cover medical, nursing and administrative workforces. JAG strongly recommends the use of JETS Workforce to support competency development and training.	• A workforce, operational or organisational policy that describes: ○ appraisals and staff development ○ managing and supporting performance.
16.2	All health care professionals involved in delivering direct patient care have demonstrable competencies relevant to their role.	C	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.	• A workforce list summary summarising: ○ who provides mentorship to newly appointed staff and student nurses ○ a description of the processes for competency assessment ○ number of student nurses, stage of training and level of support required.
16.3	A nominated mentor/trainer observes and supervises staff members until identified competencies have been achieved to demonstrate safe, independent practice.	C	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.	• A workforce list summarising who: o provides preceptorships and mentorships to new registered staff, existing staff and HCAs o 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.
16.4	There is an effective appraisal system for all staff, identifying learning needs and objectives. Additional learning should support revalidation requirements.	C	Appraisal should include other relevant information such as patient and staff complaints, 360-degree 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.	• A workforce summary of completed appraisals dates and 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).
16.5	Staff have sufficient time and resource to meet their learning needs, including when new or replacement equipment is introduced.	C	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	• 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

			competencies met for all the workforce, eg change in ERS.	
16.6	Processes address performance issues through the service leads.	B	All professionals should be provided with individual performance data sufficient to reliably inform their appraisal and revalidation 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.
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.	A	Examples of these are a professional development nurse or clinical facilitator, for example JETS Workforce.	

17. Environment, training, opportunity and resources				
17.1	Trainers and trainees use the JETS e-portfolio (or equivalent in ROI) to support training and evaluation.	C	The JETS e-portfolio enables the local training lead to plan and monitor the training lists provided in the unit.	• Evidence from a JETS export /timetables showing training lists
17.2	Training lists are available which are coordinated by a dedicated member of staff	C	This should include details of, organisation of local training and training lead.	• 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.
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.	C	See e-Learning for Healthcare for endoscopy induction e-learning.	• A formal induction programme for trainees. • Evidence of application of the above in practice (interviews with trainees on the visit day).

17.4	Feedback is obtained from endoscopy trainees on the availability of training support and the quality of the training environment	C	The JETS e-portfolio supports trainee feedback on the quality of the training received on any training list.	• Minutes to show training has been discussed to optimise opportunities for trainees.
17.5	There are processes to maximise endoscopy trainees exposure to emergency and urgent endoscopic procedures.	B	Trainees identified as 'training in gastrointestinal haemostasis' will require evidence in JETS of an agreed local mechanism to maximise exposure to gastrointestinal bleeding.	• Process that ensures endoscopy trainees' exposure to emergency and urgent endoscopic procedures detailed within training policy
17.6	The delivery of endoscopy training is reviewed in EUG or governance meetings which include trainee representation.	B	Feedback should be gained from relevant areas (such as JETS and an annual training survey) and an improvement plan created where appropriate.	• Minutes to show training has been discussed to optimise opportunities for trainees.
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.	B	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.	• 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				
18.1	There is a nominated trainer for each endoscopy trainee.	C	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.	• 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 five-year revalidation cycle.
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).	C		• A summary description of the training lead role and responsibilities for the service including the time commitment allowed to support training leadership.
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.	C	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).	• Training lead participation as a trainer in a JAG approved training course within the five-year revalidation cycle.

18.4	Endoscopy trainers' performance is reviewed and actions taken to develop trainers.	C	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	• 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).
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.	B	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).	• Minutes where trainer performance is reviewed including faculty attendance at external courses. • Trainer feedback for all trainers (eg DOTS on the JETS website).
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).	A	DOTS and LETS tools are available via the JETS e-portfolio.	

18.7	At least one trainer participates as training faculty on a JAG-approved training course annually.	A	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				
19.1	All endoscopy trainees have completed a mandatory JAG basic skills courses or have a course booked.	C		• Evidence that all endoscopy trainees have completd or booked a basic skills course.
19.2	All endoscopy trainee activity is recorded.	C		• Evidence that all endoscopy trainee activity is recorded on JETS.
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.	C		• Evidence of endoscopy trainee appraisals completed in the JETS e-portfolio.
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	C	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 of summative DOPS required for the JAG certification process.
19.5	There is a policy for defining and monitoring independent practice of endoscopy trainees	C	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.	• Policy for defining and monitoring independent practice of endoscopy trainees.

19.6	There is a visible updated register within each procedure room of trainees allowed to perform specified procedures independently.	C		• In-room competency register identifying trainees, training modality, and current level of supervision.
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.	B		• Evidence of trainee appraisal.
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.	A	It is recommended that this standard is incorporated into an annual ETR.	
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 DOPS assessments in response to the training needs	A		