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

JAG accreditation

Paediatric global rating scale (pGRS) for UK services

2025 version

Introduction

The paediatric global rating scale (pGRS) for endoscopy has been developed for use throughout the UK and beyond to underpin all aspects of a high-quality endoscopy service including clinical quality, safety, patient experience, the environment and the workforce. Below is a brief description of paediatric endoscopy services, including how they are provided and how they may differ from adult endoscopy services.

Paediatric endoscopy services

Paediatric endoscopy services refer to a specialised area of medical practice focusing on the use of endoscopic procedures for diagnosing and treating various gastrointestinal diseases and conditions in children and adolescents (<18 years of age). These services are typically provided by specialists, who are trained in performing endoscopic procedures in infants, children, and adolescents in the right environment with provision of the appropriate facilities. These include:

- Paediatric gastroenterologists. These are the primary professionals who perform paediatric endoscopy. They are doctors who have undergone specialist training in both gastroenterology and paediatric care.
- Paediatric surgeons. Paediatric surgeons may perform endoscopies including in cases involving surgical conditions.
- General paediatricians with special interest. Some general paediatricians who have received advanced training and are accredited in paediatric endoscopy can also perform endoscopic procedures.

Adult gastroenterologists may assist paediatric endoscopists with complicated interventional cases under specific circumstances, including management of life-saving emergency cases, where multidisciplinary collaboration is facilitated and clinical and medical care is guided by the senior paediatrican.

Paediatric endoscopy, in contrast to adult endoscopy, encompasses several key aspects relevant to paediatric patients, as well as paediatric and clinical practice. These include:

1. Patient age group: The services are specifically tailored for the paediatric population, which includes newborns, infants, children, and adolescents (0–16/18 years). A dedicated approach to this age group is essential because the medical needs, anatomy and physiology of children differ significantly from those of adults. This differentiation aligns with the separation of paediatric and adult services within the NHS and in other healthcare systems worldwide.

2. Diagnostic and therapeutic procedures: Paediatric endoscopy services encompass both diagnostic and therapeutic procedures. However, paediatric endoscopy services are more heavily focused on diagnostic endoscopy, and the goals are frequently different from those of

adult endoscopic services. In paediatrics, endoscopy is predominantly utilised for the diagnosis of inflammatory bowel disease (IBD), whereas cancer screening and diagnosis are more relevant in adults. Furthermore, paediatric endoscopy is typically performed under general anaesthetic in contrast to the use of sedation in adult patients.

3. Specialised equipment and techniques: Paediatric endoscopy requires equipment that is appropriately sized for children, including smaller endoscopes and specialised instruments designed for the paediatric anatomy. Additionally, the techniques used may differ from those in adult endoscopy, taking into account the unique physiological and psychological needs of children. Techniques in paediatric endoscopy are often modified to be less invasive and gentler. Children also require closer post-procedural monitoring due to their different physiological responses and the effects of anaesthesia.

4. Multidisciplinary approach: Paediatric services often involve a team approach, including paediatric gastroenterologists, paediatric surgeons, anesthetists specialised in paediatrics, paediatric nurses and dietitians. This team works together to ensure comprehensive care tailored to the needs of young patients. When endoscopic procedures are performed in paediatric theatres, there is additional communication with the paediatric anaesthetist and paediatric theatre staff. While some theatre staff may be designated to specialise in paediatric endoscopies, this may not be consistent due to the multi-use nature of theatres. This contrasts with adult GI practice, where there is typically a more dedicated endoscopy staff.

5. Setting and providers: Paediatric endoscopy services are provided in a variety of hospital settings. The providers are typically paediatric gastroenterologists but may also include other specialists trained in paediatric endoscopic procedures. These different settings can generally be divided into four groups, which include:

    a. Standalone children's hospitals
    b. Children's hospitals co-located with adult GI units
    c. District general hospitals providing paediatric endoscopy services
    d. Paediatric hepatology units offering therapeutic banding for varices

6. Patient and family-centered environment: Given the young age of the patients, paediatric endoscopy services also focus on providing support and information to families. This includes explaining procedures, discussing anaesthesia options, and providing post-procedure care instructions. This should be delivered in a child-friendly environment by staff who are experienced in providing this service. Typically, this would take place in a day ward setting, from where the children would be taken to theatres for their anaesthetic and procedure.

7. Paediatric endoscopy services differ from adult endoscopy services in that paediatric endoscopy is not typically provided in standalone units. Standalone paediatric endoscopy suites, which are common in adult practice, are rare. All rules and regulations, including

legislation of practice, child protection policies, and standard operating procedures for all paediatric hospital admissions, apply to endoscopy undertaken in children. Addressing the full breadth of such policies observed in the operation of children's units is beyond the scope of this document, and it is expected that paediatric endoscopy services will follow local paediatric policies and procedures supporting the care of children in hospital settings. The RCPCH (Royal College of Paediatrics and Child Health) has developed several standards for acute paediatric care, paediatric assessment units, emergency care settings, emergency departments, high dependency care for children, and child protection service delivery standards.

Development of pGRS (2025 update)

The 2025 update to pGRS has been undertaken to:

1. Consider recent developments in endoscopy and the effects of the COVID-19 pandemic, which have generally resulted in more accessible and user-friendly IT and software in paediatric practices.
2. Place a greater focus on outcomes. In parallel, the development of paediatric endoscopy pathways has been reviewed, with KPIs serving as key indicators of progression. This aligns with the 2021 adult GRS.
3. Please refer to the published *Quality Standards for Specialist Paediatric Gastroenterology* by the Royal College of Paediatrics and Child Health. This guidance aims to reduce variation in care, ensure equitable services, and improve the health outcomes and quality of life for all infants, children, and young people with gastroenterology, liver or intestinal disorders in the UK. Please also refer to the metrics for quality standards in paediatric endoscopy outlined in the JAG document - *Guide to meeting the quality and standards in paediatric endoscopy*.

This document contains the pGRS standards and guidance for all paediatric services in the UK. The document aims to cover the practice remit of the four types of paediatric endoscopic units. It is therefore logical that some standards may not be relevant where a service is not delivered (for example, use of general anaesthetic/sedation for paediatric endoscopies); endoscopy services can mark these as non-applicable where appropriate.

For combined paediatric and adult endoscopy services, it is anticipated that two global rating scales (GRS) should be completed.

The standards

Each standard details what a paediatric 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
- A – this is exemplary practice which goes above and beyond best practice. All services are encouraged to aim towards this level

Is evidence required?

Paediatric services are not required to upload evidence at this time. Self-assessments are to be used as a quality improvement tool.

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

No.	Measure	Level	Guidance
1. Leadership and organisation			
1.1	There is a defined paediatric endoscopic management structure, which includes leadership and governance responsibilities related to paediatric endoscopy in clinical, nursing, and theatre areas, with protected time allocated in job plans.	C	Regular meetings with the local paediatric endoscopy user group (see 1.3) will help establish the local management structure and enhance the team's understanding of roles within the overarching service. The leadership team should seek staff feedback to assess their effectiveness, for example, through a 360-degree feedback process.
1.2	Clear information is available about the range of paediatric endoscopy procedures provided by the hospital and at any associated sites.	C	The service description and procedures offered should typically be available on the hospital's website (or an easily accessible alternative source) for everyone to access. This information should be provided in formats and languages appropriate for the local population. The team may also consider developing video information. It should also specify whether the service is a standalone service or operates across multiple sites, if relevant.
1.3	There are defined paediatric endoscopy governance meetings within the service that support organisation and delivery	C	The Paediatric Endoscopy Users Group (pEUG) is the main paediatric endoscopy governance meeting. Communication structures should clearly outline how information is shared with all staff, including alerts, changes in practice, and how decisions are communicated.
1.4	There are processes and timescales to review and maintain all policies and standard operating procedures related to paediatric endoscopy.	C	This is likely to be developed by the paediatric endoscopy lead and the related team. This will form part of the hospital's document management system or a locally devised system. All key documents should have designated owners, and review dates should be recorded.
1.5	There is an annual audit plan for the service with named leads and timescales.	B	There is an annual audit plan for the service with named leads and timescales. Refer to point number 7 for paediatric endoscopy services (Introduction section).

			Standard 4 Metrics (Quality Standards for Paediatric Gastrenterology, Hepatology and Nutrition) JAG quality and safety guidance NED has not been adopted by paediatric units for various reasons. This, however, should not preclude the necessity for yearly audits, which remain a key part of governance for maintaining standards in paediatric endoscopy.
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.	A	This includes a National Endoscopy Database (NED) compliant endoscopy reporting system for paediatrics and other data capture systems related to paediatric endoscopy for productivity. Practices where NED has not been implemented should have provisions for capturing data, including local IT systems to facilitate the collection of local data. This also encompasses JAG quality improvement audits.
1.7	The paediatric leadership team reviews and plans how to meet the service's strategic objectives annually, including 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, regional referring hospitals and other representative organisations.
1.8	The paediatric leadership team and workforce engage in innovation, sharing quality improvements and research (where appropriate) with other endoscopy services at local, regional, and/or national levels.	B	This could include attending learning events, visiting other services, sharing methodologies, etc. Paediatric endoscopists could adopt a system similar to that of adult GI colleagues, as seen on the JAG website, for learning opportunities—for example, the safety case of the month.
1.9	The service should have green endoscopy on their agenda and can address it in a forum (adult endoscopy, hospital) for promoting and implementing green theatre and green endoscopy practices	A	An example of this is an initiative to reduce waste in endoscopy. 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	Paediatric endoscopy services should aim to discuss adverse events and address them within the children's morbidity and mortality (M&M) meetings. It is advisable to extend these discussions beyond the paediatric endoscopy user group to the broader general paediatric M&M meetings, particularly in specialist centres. This integration into the wider paediatric unit's morbidity and mortality meeting practices is crucial for comprehensive care. Refer to the RCPCH paediatric gastroenterology Quality Standards
2.2	A pre- and post-procedure safety checklist is used and discussed in team brief for each paediatric endoscopy list.	C	The WHO surgical safety checklist was developed to reduce errors and adverse events, increasing teamwork and communication in procedures (paediatric endoscopy) WHO Surgical Safety Checklist
2.3	Children and young people's fitness for oral bowel cleansing agents is assessed and documented before bowel preparation is dispensed or prescribed.	C	Please refer to the metrics for quality standards in paediatric endoscopy outlined in the JAG document, 'Guide to meeting the quality and standards in paediatric endoscopy'. It is important to address assessment of any patient comorbidities, including type 1 diabetes, obesity, airway compromise, coagulopathies, immune deficiencies, cardiac disease, as well as neurodevelopmental and psychiatric conditions. This also encompasses the assessment of fitness for bowel preparation and the endoscopic procedure.
2.4	The local leadership team reviews adverse events at least every three months. This information is shared regionally and nationally where appropriate.	C	Refer to 2.1. Paediatric endoscopy units that have not yet engaged with NED are encouraged to do so. Paediatric endoscopists are urged to establish networks within their peer groups, such as BSPGHAN for discussion about difficult endoscopy cases. NCEPOD (National Confidential Enquiry into Patient Outcome and Death) is an independent organisation commissioned by the Health Quality Improvement Partnership. NCEPOD is a UK body that reviews patient care and deaths

2.5	Establish a robust pre-assessment process that addresses co-morbidities, with identified risks in paediatric patients undergoing endoscopy. In non-children's hospitals or general paediatric settings, consultations should take place with specialist teams, or relevant protocols should be consulted.	C	Refer to the RCPCH paediatric gastroenterology Quality Standards metrics for quality standards in paediatric endoscopy outlined in the JAG document, 'Guide to meeting the quality and standards in paediatric endoscopy'.
2.6	The paediatric endoscopist, anaesthetist, and endoscopy/theatre staff meet before each list to identify any potential risks or issues (Team Brief).	C	The focus of this should be to share safety learnings and to identify potential patient issues relevant to the procedure, from both the endoscopy and anaesthetic perspectives. This includes considerations around the environment, equipment, infection control, staffing issues, and ensuring all team members are aware of how to contact emergency back-up cover if required.
2.7	Paediatric units should have local upper and lower paediatric gastrointestinal bleeding management guidance/pathways, implemented by the endoscopy leadership team	C	Paediatric gastroenterology services are usually provided within a regional network, serving a group of hospitals that refer children with gastrointestinal (GI) conditions, including bleeding. Therefore, the management of children with GI bleeding should be guided by locally or regionally agreed protocols and pathways. Supra-specialised paediatric hepatology units are commissioned by NHS England for the management of variceal bleeding, and the guidance pathway should be established in collaboration with the paediatric hepatology units, with agreed referral pathways.
2.8	A process is in place for identifying, reviewing, and reporting deaths related to endoscopy and any child protection issues.	B	Outcomes of reviews should be reported through EUG/governance meetings and, where relevant, discussed in the hospital paediatric M&M meeting. NCEPOD (National Confidential Enquiry into Patient Outcome and Death) is an independent organisation commissioned by the Healthcare Quality Improvement Partnership. NCEPOD is a UK body that reviews patient care and deaths. All child protection concerns must be escalated to the local child protection team and managed accordingly.

3. Comfort (ONLY FOR PAEDIATRIC UNITS USING SEDATION FOR PAEDIATRIC ENDOSCOPY – THOSE DOING ENDOSCOPY UNDER GA should GO TO SECTION 4)			
3.1	Paediatric patients receive timely information providing a realistic description of the level of discomfort possible during the procedure	C	Patient information and pre-assessment should explain potential discomfort to all paediatric patients and the range of options for sedation.
3.2	Paediatric endoscopists monitor and record patient pain and comfort levels during and after the procedure using a validated scoring scale.	C	A comfort assessment should be conducted for all paediatric endoscopy procedures, regardless of the level of sedation. It is the responsibility of both the paediatric practitioner and the airway practitioner to attend to the needs of the patient throughout the procedure and to monitor their comfort. Sedation may also influence the patient's perception of discomfort. Paediatric patients should be asked directly about their pain and comfort levels both during and after the procedure.
3.3	Patients are supported if they become distressed or wish to stop the procedure	C	The comfort of all paediatric patients during procedures is everyone's responsibility. Every member of the paediatric team has a role in acting as the patient's advocate, ensuring that the procedure is paused and reviewed if there is any distress, and even discontinued if necessary.
3.4	Patient comfort scores are reviewed biannually by the leadership team and shared with individual paediatric endoscopists. If scores fall below agreed levels, the clinical lead or governance committee reviews the endoscopist's practice.	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.
3.5	The service is able to use CO_2 insufflation and provide N_2O inhalation for patients undergoing GI procedures.	A	

3.6	The service offers a full range of sedation techniques to maximise comfort, reduce anxiety in children and teenagers, and perform complex endoscopy in line with accepted practice.	A	A full range of sedation techniques means that the paediatric patient is aware of the full options available to them and what is safe and appropriate for that patients' needs.
3.7	The airway in paediatric patients should be monitored and maintained by a trained paediatric airway practitioner, preferably an anaesthetist with paediatric training.	C	

4. Quality			
4.1	Individual paediatric endoscopists receive feedback on their key performance indicators (KPIs) for procedures at least once a year, using local records and audit systems. This should occur more frequently if adverse events or potential issues are identified.	C	Refer to the metrics for quality standards in paediatric endoscopy outlined in the JAG document, 'Guide to meeting the quality and standards in paediatric endoscopy'.
4.2	Individual paediatric endoscopists receive feedback on their safety outcomes at least once a year.	C	Refer to the RCPCH paediatric gastroenterology Quality Standards Refer to standard 4, regarding collation of activity data on patient safety. Refer to the metrics for quality standards in paediatric endoscopy outlined in the JAG document, 'Guide to meeting the quality and standards in paediatric endoscopy'.
4.3	Local systems are in place to manage underperformance if an individual paediatric endoscopist's performance levels are not achieved.	C	See JAG guidance on managing endoscopist underperformance. These JAG guidance principles equally apply to an underperforming paediatric gastroenterologist as to an adult endoscopy practitioner.
4.4	An Endoscopy Reporting System (ERS) captures immediate procedural and performance data.	B	This includes cases performed outside the endoscopy unit, such as emergency procedures, those in radiology, and procedures involving paediatric patients.
4.5	The ERS actively uploads all paediatric gastrointestinal (GI) endoscopy procedures to the National Endoscopy Database (NED) using compliant software, and meets the ongoing data validation requirements.	A	See the NED website
4.6	The service collects data for all patients who undergo endoscopy, including indication, waiting times and relevant auditable outcomes.	B	

5. Appropriateness			
5.1	Vetting for endoscopy in paediatric patients should be carried out by a consultant paediatric gastroenterologist or lead clinician.	C	The 'straight to test' practice is not acceptable in paediatrics
5.2	Paediatric endoscopy should be performed only for appropriate indications, as outlined in both national and international guidelines.	C	Refer to the metrics for quality standards in paediatric endoscopy outlined in the JAG document, 'Guide to meeting the quality and standards in paediatric endoscopy'.
5.3	The vetting process is reviewed annually, and action plans are developed to address any issues.	B	Outcomes and action plans should be agreed at the endoscopy EUG.

6. Results			
6.1	Endoscopy reports for all inpatients are added to the patient's record before they leave the department. In modern paediatric practice, these are typically digital records.	C	
6.2	Endoscopy reports are completed on the day of the procedure and include follow-up details. They are sent to the patient's referring clinician (usually a paediatrician) and GP within 24 hours of the procedure.	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, however, it is expected that a service will work towards this. JAG recommends that reports are sent electronically.
6.3	The turnaround time for histopathology reporting is within 3 weeks. Once reported, pathology reports are accessible without undue delay.	C	
6.4	There is a process for the responsibility of clinical actions resulting from the pathology reports.	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.

7. Respect and dignity			
7.1	There is a policy on respect, dignity, and security, which encompasses care of all paediatric patients accessing the service.	C	This should include how the endoscopy service provides a comprehensive service to all paediatric patients. All children, regardless of postcode, have equal access to high-quality care, tailored to their individual needs. Examples of how respect and dignity might be applied in practice in endoscopy include: - Offering privacy to children and families during any discussions, consent and examination - Demonstrating understanding for cultural differences. For instance, understanding dietary restrictions, modesty concerns, or specific practices related to religious observances - Lockable toilets and privacy curtains - Understanding needs for children and families with any eg neurologic disabilities and autism. Some autistic children may be averse to loud ward noises. See: JAG environment guidance Babies, children and young people's experience of healthcare. NICE GUIDELINE (NG204)
7.2	There is a safeguarding policy for children, with a nominated child protection lead in the department.	C	See: RCPCH Child protection service delivery standards
7.3	There is a nominated Dignity policy for all paediatric patients using the service.	C	Some trusts may have appointed dignity champions for paediatrics. In the absence of a dignity champion, healthcare professionals, such as paediatric nurses and clinicians, play vital roles in advocating for and upholding the dignity of paediatric patients. A dignity policy for paediatric unit is to ensure that children are treated with respect and dignity and their privacy is protected.

7.4	There should be clear separation between adult and paediatric patients for admission, procedures, and recovery if paediatric patients are treated in an adult endoscopy suite.	C	See: JAG environment guidance Please refer to the Royal College of Nursing - *Caring for Children and Young People*
7.5	Paediatric staff are trained to act with discretion and respect towards all patients and carers, with the ability to raise any safeguarding concerns if needed.	C	Training for paediatric staff will be organisation-wide, led by an overarching paediatric unit. Please refer to the Royal College of Nursing - *Caring for Children and Young People* See Good Medical Practice (GMC)
7.6	Paediatric patients' confidentiality, privacy and dignity are 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. - patient-identifiable material is not displayed in areas accessible to patients or the public.

8. Consent and patient information			
8.1	There is a patient information sheet for all relevant procedures given to patients ahead of the procedure (diagnostic and therapeutic)	C	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.
8.2	There is a policy in place for updating paediatric consent during an endoscopic procedure under sedation or general anaesthetic.	C	The clinical team should pause the procedure and seek consent from the parent/guardian. Due diligence should be given to the fact that permission given under any unfair or undue pressure (particularly if the child is under anaesthetic) is NOT valid consent. However, in the case of an emergency, endoscopists may proceed if delaying the procedure would harm the child's health.
8.3	The requesting clinician documents the assessment of bowel preparation dose and patient's fitness for oral bowel cleansing agents before dispensing to the paediatric patient.	C	Prescribing bowel preparation for paediatric endoscopy is challenging due to the need for accurate dosing based on size and weight, which can vary widely in children even at the same age. Additionally, other diagnoses or underlying conditions eg cardiac, renal, respiratory and neurologic conditions may affect tolerance and safety of bowel cleansing agents and should be carefully considered.
8.4	Consent forms are signed by the child/teen who is competent or has capacity before the procedure. If the child lacks capacity or competence, the parent or legal guardian gives consent. Paediatric patients and carers are given sufficient time to ask questions or raise concerns.	C	See GMC – 0-18 years: guidance for all doctors

8.5	High-risk patients and those scheduled for 'high-risk' procedures are pre- assessed to discuss risks and benefits, with this documented in line with informed consent.	C	See: Best Practice Guideline: Preassessment services for children undergoing surgery or procedures. Association of Paediatric Anaesthetists of Great Britain and Ireland Pre-assessment clinics: Should every child have access to a consultant anaesthetist? Association of Paediatric Anaesthetists of Great Britain and Ireland 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 for eg variceal banding in a child with liver disease and upper GI bleed.
8.6	All paediatric patients undergoing endoscopy have their risks and assessments documented by the paediatric endoscopist before the procedure.		
8.7	All paediatric endoscopy units must ensure the provision of age-appropriate endoscopic equipment to meet the specific requirements of paediatric patients across all age groups.	B	This activity should be included in the EUG or equivalent.

9. Patient environment and equipment			
9.1	There is a description of the paediatric endoscopy facilities available for paediatric 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.
9.2	THIS STATEMENT IS ONLY FOR STANDALONE CHILDREN HOSPITALS WITHOUT COHABITANT ADULT ENDOSCOPY UNITS Decontamination equipment is tested and validated according to national guidance and action is taken on results which fall outside acceptable parameters.	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 Health Technical Memorandum 01-06: Decontamination of flexible endoscopes
9.3	An annual review of the facilities and environment is conducted to ensure they are child-friendly and support the effective delivery of services.	C	The infrastructure/facilities meet the specific needs of all paediatric 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. See: JAG environment guidance
9.4	THIS STATEMENT IS ONLY FOR STANDALONE CHILDREN HOSPITALS WITHOUT COHABITANT ADULT ENDOSCOPY UNITS 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.
9.5	There is an annual review of equipment including endoscopes and a process for replacement.	B	This should include a risk assessment of kit if not replaced.

9.6	All areas are child friendly and well maintained and support efficient paediatric patient flow and ergonomic and efficient working. Access is restricted as appropriate.	B	See: JAG environment guidance The patient pathway/facilities will be examined during the site assessment.
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.

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.
10.2	There is an electronic scheduling system that facilitates efficient booking and scheduling as well as capacity planning.	C	
10.3	There is a patient-centred booking system.	B	The focus should be on preparing, involving, and organising with consideration for the child's needs. The process should be seamless, starting with the child's review in the clinic, the decision about endoscopy, the booking process, pre-endoscopic assessment, leading to the procedure, followed by effective communication with the child, their family, and the clinicians involved from other centres. If a child requires two anaesthetics for different procedures, efforts should be made to perform both procedures under one anaesthetic unless clinically not possible. This will require effective communication between the two medical teams treating the child.
10.4	All appropriately vetted urgent paediatric upper GI and colonoscopies are performed within 1 to 14 days, depending on the specific indication.	A	The terms urgent and emergency have distinct meanings within paediatric endoscopy practice. Emergency refers to situations requiring immediate intervention (typically within hours), such as the removal of an ingested button battery or managing gastrointestinal bleeding in a haemodynamically unstable child, in order to prevent significant morbidity or mortality. These situations are life-threatening or pose an immediate risk to the child's health. Urgent endoscopy refers to procedures which, while needing prompt attention, can safely be deferred for a short period (for example, assessment of a child presenting with severe inflammatory bowel disease) without significantly increasing clinical risk or adversely affecting the patient's outcome.

10.5	All appropriately vetted emergency upper GI and colonoscopy procedures are performed within 24 hours	A	Refer to the metrics for quality standards in paediatric endoscopy outlined in the JAG document, 'Guide to meeting the quality and standards in paediatric endoscopy'.

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.
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.
11.3	The service offers a pre-check to identify issues and prevent cancellations. This may be done separately or as part of the outpatient clinic review by the responsible clinician.	B	This ensures that the service has up-to-date information about the paediatric patient's condition and medications. This is mostly carried out during the clinic appointment preceding the endoscopy by the clinician leading the child's care. Alternatively, it could be a telephone assessment, but in paediatrics, it should always be led by the medical team directly managing the child's procedure.
11.4	There is an annual planning and productivity report for the service with an action plan.	A	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.

12. Aftercare			
12.1	There are procedure-specific aftercare patient information leaflets for all procedures performed.	C	The leaflets should cover all diagnostic and therapeutic endoscopy procedures for children.
12.2	24-hour access is provided for paediatric patients and their carers who experience issues or problems post-endoscopy.	C	It is the responsibility of the paediatric endoscopy team to make these arrangements and provide the correct details to the patient and the hospital switchboard (including out of hours), as relevant. The contact number may be staffed by nursing staff on a paediatric ward, a paediatric registrar, a paediatric gastroenterology consultant, or A&E (if agreed beforehand), with the provision to undertake further investigations or even re-scope if necessary (out of hours).
12.3	Patients and carers are informed of the outcome of the procedure and ongoing care, accompanied by a copy of the endoscopy report (or a patient-friendly version).	B	Patients may be advised that they will be followed up to discuss the histology report and further clinical plans. This may be a face-to-face or telephone appointment, depending on clinical need and the convenience of the patient and their family.

13. Patient involvement			
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.	C	This could include verbal, written and web-based feedback using systems set up by the hospital. Services should consider how the needs of diverse communities are met.
13.2	Complaints are reported, investigated, and recorded. Findings are shared with relevant parties and acted upon.	C	The complaints procedure should be available for patients and carers to access.
13.3	Patient feedback and agreed actions are disseminated and discussed at EUG (or equivalent) and practitioner meetings to ensure learning.	C	
13.4	The service conducts a feedback survey of patients' and carers' experiences in endoscopy at least annually. Actions are reviewed to ensure issues are resolved.	B	This could form part of the paediatric endoscopists' feedback for their own clinical portfolios. Other teams, such as paediatric surgical teams who may perform endoscopy, particularly at different sites or theatres, should endeavour to undertake this as well.
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.
13.6	Patients participate in developing and evaluating services.	A	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

14. Teamwork			
14.1	Role (and competency level) of each member of the paediatric endoscopy team is discussed at team brief.	C	Unlike adult endoscopy teams, paediatric endoscopy usually involves three teams: the paediatric GI team, the anaesthetic team, and the theatre team. The theatre and anaesthetic staff are managed by their respective teams. On the day of the endoscopy, some members may not have worked together before, making communication—starting with self-introduction, outlining roles, and confirming competencies at the 'team brief'—extremely important. It is also essential to discuss who to contact in an emergency during this brief.
14.2	Staff from different teams (theatres, anaesthetics, paediatric ward, paediatric endoscopists, booking clerks) involved in running the paediatric endoscopy service understand their roles, with EUG highlighting key responsibilities for operating the service.	C	There are usually four or five distinct teams managing paediatric endoscopy, and good communication between them (typically via EUG) is key to the seamless running of the service: – Paediatric ward – responsible for understanding the throughput of the ward – Operating theatre staff – Anaesthetic staff – Paediatric endoscopists – The Unit Office or booking office, who are usually the first point of contact once the procedure is agreed, often sending information establishing initial communication with families.
14.3	There are structured handovers for briefing and debriefing at each list to ensure safe efficient practices during lists and effective learning.	C	This is key to seamless paediatric endoscopy procedures, given the involvement of different teams (with changing staff). See 14.2. See Safe Surgery Saves Lives, World Alliance for Patient Safety, WHO 2008 Debriefing at the end of endoscopic procedures is about sharing lessons learned, recording in a red book to discuss in EUG, and commending team members on what has been done well.
14.4	The paediatric endoscopy team and paediatric service users are surveyed biennially (2 yearly) on service delivery and improvements. Actions are taken and reviewed post-survey to ensure progress.	C	The survey should be reviewed by all members of the EUG. However, the team should continuously review informal feedback or lessons learned from debriefs of paediatric endoscopic procedures, with a view to immediately incorporate into endoscopy practice.
14.5	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.

14.6	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 1 day out together from normal service to undertake the review separate to the EUG or governance meeting.
14.7	Paediatric endoscopy services have a clear policy for offering endoscopy and after care to patients between 16-18 years of age	C	The paediatric to adult transition age varies across the UK, ranging from 16 to 18 years. This can even differ between teams within the same hospital. To avoid confusion and interruption of clinical care, individual hospitals should have a clear policy on where 16 to 18-year-olds will attend endoscopic procedures, and this information should be clearly communicated to all referrers. 16 to 18-year-olds may already be in a transition service, and there should be clear planning for their transition, depending on local policy. See: RCPCH Transition to adult services

15. Workforce delivery			
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.
15.3	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.
15.4	Workforce development plans anticipate the volume and type of future demand, for the next 2–5 years.	B	
15.5	There is a process for the recruitment and induction of senior staff which allows a handover period.	A	There should be processes and an escalation plan to ensure continuity of service without compromising safety or quality. For example, a new paediatric gastroenterology consultant may require additional support from colleagues, even if they are fully accredited for paediatric colonoscopy procedures.

16. Professional development			
16.1	It is the responsibility of individual teams contributing to the paediatric endoscopy service to ensure appropriate staff receive training for carrying out paediatric endoscopy.	C	There are usually four or five distinct teams managing paediatric endoscopy, and good communication between them (typically via EUG) is key to the seamless running of the service: – Paediatric ward – responsible for understanding the throughput of the ward – Operating theatre staff – Anaesthetic staff – Paediatric endoscopists The Unit Office or booking office, who are usually the first point of contact once the procedure is agreed, often sending information establishing initial communication with families.
16.2	All staff involved in paediatric endoscopy should discuss their training needs during regular appraisals. Additional learning should support revalidation requirements.	C	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.
16.3	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 competencies met for all the workforce, eg change in ERS. This also applies to endoscopists using new equipment or who may be accustomed to other systems.
16.4	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.

17. Environment, training, opportunity and resources			
17.1	Paediatric endoscopy trainers and trainees use the JETS e-portfolio 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.
17.2	Paediatric training lists are arranged, and dates are agreed upon by both the trainer and trainee.	C	This should include details of local training organisation and the training lead. There are limiting factors in training, such as trainees being on: – study leave – annual leave – out of-hours commitments – fulfilling other commitments they cannot leave. Compared to adult endoscopy practice, paediatric endoscopy lists are limited, so mutual arrangements regarding lists are important. Trainees are responsible for their own training and should take the initiative to seek additional opportunities.
17.3	There is an endoscopy induction programme for all new paediatric endoscopy trainees which references all key quality indicators. This is reviewed and updated annually.	B	See e-Learning for Healthcare for endoscopy induction e-learning.
17.4	Feedback is obtained from paediatric 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.
17.5	The delivery of paediatric 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.

18. Trainer allocation and skills			
18.1	There is a nominated trainer for each paediatric 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.
18.2	A nominated local training lead has overall responsibility for ensuring the induction and appraisal of paediatric endoscopy trainees (with recognised time in their job plan).	C	
18.3	The local paediatric 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).
18.4	Endoscopy trainers' performance is reviewed, and actions taken to develop trainers.	A	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.
18.5	All paediatric endoscopy 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).

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.

19. Assessment and appraisal			
19.1	All paediatric endoscopy trainees have completed a mandatory JAG basic skills courses or have a course booked.	C	
19.2	All paediatric endoscopy trainee activity is recorded.	C	
19.3	There is an appraisal completed (for example, in the JETS e-portfolio) for all paediatric endoscopy trainees commencing their training to identify their learning needs.	C	
19.4	There is an assessment of paediatric trainees 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.
19.5	There is a policy for defining and monitoring independent practice of Paediatric 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.
19.6	Paediatric endoscopy trainees have an appraisal with their trainer (this should be completed on the JETS e-portfolio for all trainees) at least annually.	B	

19.7	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 endoscopy training review (ETR).
19.8	There should be provision for an intermediate appraisal (e.g. after 6 months), particularly if any issues are highlighted at the first appraisal or arise during the course of training.	A	
19.9	Paediatric training lists are actively modified and action plans documented on direct observation of procedural skills (DOPS) assessments in response to the training needs	A	

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