Royal College of Physicians

JAG Joint Advisory Group on GI Endoscopy

JAG accreditation

Accreditation standards for Republic of Ireland services

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Contents

Introduction 2

The standards 3

The evidence 3

1. Leadership and organisation 4

2. Quality 8

3. Safety 11

4. Appropriateness and access 16

5. Consent and patient information 20

6. Person-centred care 22

7. Performance and productivity 27

8. Results 28

9. Patient environment and equipment 30

10. Staffing the endoscopy service 32

11. Endoscopist training 39

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Introduction

The JAG Accreditation Programme aims to support services in improving the quality of the service that they provide to patients and staff, using the structured framework of the Global Rating Scale (GRS). This is achieved through a fair and consistent approach of assessing against clinically approved standards, to ensure that services are supported to achieve accreditation where possible.

Any additions to the GRS standards will be appropriate and achievable for services, ensuring that quality improvement continues to be at the centre of all the work that we ask services to undertake, while working to make them clinically robust and aspiring, but also realistic.

The 2026 update to the standards (GRS) has been undertaken to:

- ensure that the standards reflect up-to-date guidance and remain relevant to endoscopy services
- reduce duplication of standards and therefore evidence requirements, while retaining the same high-quality
- create fewer domains for services to work through, with improved flow through the domains to help services engage in the standards
- provide clearer guidance on which areas impact particular parts of the workforce
- include PCCRC guidance
- remove the GRS census requirement in 2023. The GRS levels have been removed. Services are now required to demonstrate that they meet every standard in the document.

This document contains the accreditation standards, guidance and evidence requirements for all adult services in the Republic of Ireland. Some standards may not be relevant where a service is not delivered (for example, providing an inpatient service); there are non-applicable options for services to mark where appropriate.

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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. Previously, services had to demonstrate that they meet standards according to a level system; this has now been removed, and services must demonstrate that they meet the requirements of every standard.

There are 11 domains, with 80 individual standards:

1. Leadership and organisation
2. Quality
3. Safety
4. Appropriateness and access
5. Consent and patient information
6. Person-centred care
7. Performance and productivity
8. Results
9. Patient environment and equipment
10. Staffing the endoscopy service
11. Endoscopist training

The evidence

Services can access the standards by opening a self-assessment on the website and begin working towards accreditation. Evidence should be uploaded to the JAG website to show compliance for each standard, and suggested evidence is listed in this guide. The evidence is designed to be as simple and easy to gather as possible, while providing a robust assessment of a service. In some examples, the guidance links to other guidance documents and templates for services to use. The evidence requirements are not prescriptive, and services may provide alternative evidence as long as it can be uploaded to the JAG website.

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

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1. Leadership and organisation

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

Guidance

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

JAG expects that the clinical lead scopes within the unit. This will usually be a gastroenterologist or surgeon.

The clinical lead will oversee clinical quality and safety, contribute to endoscopy user group (EUG) presentations and discussions, and review clinical KPIs, including taking action where required. The individual should have adequate protected time to fulfil the role. In hospitals with established governance, 4 hours per week of protected time is strongly advised, with additional time recommended for larger units or where further clinical leadership support might be required. Within private hospitals, in smaller departments where the lead is supported in obtaining audits, KPIs and endoscopist whole-practice data, an ad-hoc sessional agreement reflecting a much lower time commitment may be sufficient.

Management lead: Time commitments must reflect the activities required to manage performance and the development of the service, including insourcing and JAG support. More than one role may support these functions.

Evidence

- 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 and QA functions.
- Feedback about leadership and governance performance.

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

Guidance

The service should have a defined documented meeting structure that covers:

- management and performance, including waiting list and productivity performance, weekly capacity planning and administration huddles
- safety and governance, including endoscopy EUG/governance
- nursing: weekly and monthly meetings showing how staff are listened to and changes in practice are communicated
- decontamination, including operational delivery and IHEEM (Institute of Healthcare Engineering and Estate Management) compliance. This must be included even if decontamination is managed by another area. It is expected that there are meetings to ensure safe operational delivery.

The meeting structure should be mapped showing clear purpose and lines of reporting within endoscopy and beyond.

Evidence

A description of the reporting governance and performance structure that includes as a minimum:

- management and administration meetings to support performance, business planning and service delivery day to day
- governance meetings (EUG or other) including terms of reference/agenda
- workforce meetings (nursing, admin etc)
- decontamination meetings
- assessment of impact of communication structure through staff feedback.

1.3: There are processes and timescales to review and maintain all endoscopy policies and standard operating procedures (SOPs).

Guidance

This should be a hospital document management system or locally devised system that identifies review dates and owners for all key endoscopy documents.

Evidence

Evidence of a system of document management that includes owners and review dates for all key documents.

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

Guidance

See the JAG quality and safety guidance.

This now includes ERCP (endoscopic retrograde cholangiopancreatography) and PCCRC (post-colonoscopy colorectal cancer) audits.

The list of audits should include review of NQAIS (National Quality Assurance and Improvement System) data (see National GI Endoscopy Quality Improvement guidelines).

Evidence

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

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1.5: The service has internal adequate technical support for data, audits and quality assurance to operate and improve the service.

Guidance

JAG expects to see clear roles in quality assurance and audit support that reflect the needs of the service.

Evidence

Summary of managerial, administrative and technical support for the service and key functions, including endoscopy reporting tools, Business Intelligence Unit (BIU) support for performance data, and JAG QA support.

1.6: The leadership team reviews and plans how to meet the service's strategic objectives annually, including for any service developments.

Guidance

This is an opportunity to look back at what has been achieved and to plan.

Services should consider how they engage with local populations and their representative organisations.

Evidence

Annual review of the service strategy, objectives and resources including a plan that summarises deliverables for the service. Refer to other standards, ie annual skill mix review, annual review of productivity, demand and capacity projections. Sessions required and workforce requirements.

A business plan (if applicable) to support new developments (eg kit, workforce, environment, capacity).

Projected demand for at least 12 months. Consideration of endoscopist provision, detailing projections of list reduction because of training, retirement, or alteration in job plans, and a costed plan to fill gaps. Projections should be used to guide recruitment, job planning and training.

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

Guidance

This could be attendance at learning events, visiting other services, sharing methodology etc.

Evidence

Examples of innovation, sharing of quality improvements or research.

Description of how the service interacts within the local GI endoscopy network.

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

Guidance

JAG expects to see clear roles in quality assurance.

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

See JAG guidance.

Evidence

Minutes and discussion of green endoscopy within EUG.

Description of green initiatives.

1.9: The service provides clear information about all endoscopy procedures.

Guidance

Must include associated sites and insourcing providers.

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

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

Evidence

Description of the service, including all linked or affiliated services – including relationships with other endoscopy services, patient groups and services that share a common purpose.

A summary description of the service for referrers, patients and their carers. This should be on a website and available in paper format.

Feedback from referrers, patients and their carers.

1.10: The service leadership team listens to the team and promotes the health and wellbeing of staff members.

Evidence

Operational policy or SOP that includes a section on supporting team members. This can be a hospital or regional policy.

Examples of how this is delivered (this may be discussed at assessment).

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2. Quality

2.1: A matrix of endoscopists' competencies for all procedures undertaken is visible within the service.

Guidance

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

Evidence

Matrix of staff competencies for all procedures undertaken.

2.2: Procedural key performance indicators (KPIs), including comfort scores, are fed back to individual endoscopists by the clinical lead at least twice per year. If KPIs fall below agreed levels, the endoscopist's practice is reviewed by the clinical lead and/or governance committee.

Guidance

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

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

Includes individual feedback and KPIs on ERCP if performed.

Evidence

- Use mandatory templates 1 and 2 or equivalent.
- Process to monitor the relevant quality standards for endoscopy.
- Process to assess the KPIs and competency of any new endoscopist. This should be for all grades, including new consultants, trainees and, critically, locums.
- EUG minutes showing evidence of feedback from KPI audits and agreed action plans (two sets over 1 year is the minimum evidence requirement).
- Evidence that individual endoscopists are given feedback on their procedure KPIs, including comfort, at least twice a year and actions taken where KPIs are not met.
- Policy document outlining process for patient selection and consent, training requirements for performing and assisting staff and supporting governance processes.
- Audit of all cases to be performed at least annually, including procedural numbers, success, complications and outcomes, and rates of recurrence.
- EUG minutes providing evidence of critical review of outcomes, where possible compared with published data to validate procedural efficacy and safety.

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

Guidance

The specific BSG (British Society of Gastroenterology) safety outcomes that require review are described in the JAG quality and safety guidance. This is to include PCCRC and procedural complications.

PEUGIC (post-endoscopy upper gastrointestinal cancer) is not currently mandated for the Republic of Ireland.

Evidence

- Evidence that individual endoscopists are given feedback on their safety outcomes at least annually (eg PCCRC).
- Minutes that show any PCCRC that has arisen in the service (cancer diagnosed within 3 years after a colonoscopy/gastroscopy has been performed) with action planned as required.
- Operational policy that describes how PCCRCs are identified and acted upon.
- Description of how complications are identified and recorded (might include links with surrounding admitting hospitals, scheduled post-procedure phone calls to patients, 30-day mortality and 8-day readmissions).
- List of procedural complications and actions taken in response.

2.4: If individual endoscopist performance levels are not achieved, the endoscopy lead manages underperformance according to JAG guidance.

Guidance

See JAG guidance on managing endoscopist underperformance.

Evidence

- 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.

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2.5: An endoscopy reporting system (ERS) captures immediate procedural and performance data. The ERS uploads GI endoscopy procedures to NQAIS.

Guidance

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

See the National GI Endoscopy Quality Improvement (NEQI) Programme website.

Evidence

Evidence of NEQI programme participation.

2.6: The service collects data on all 'off-unit' GI endoscopy that occurs in the organisation and captures this on the ERS.

Guidance

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

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

Evidence

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

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3. Safety

3.1: Endoscopy-related incidents and key safety indicators are recorded, monitored and acted upon with review every quarter by the senior leadership team. This is shared locally and nationally where appropriate.

Guidance

Robust system for identifying and recording, monitoring, acting upon and sharing adverse events and key safety indicators. This should be supported by appropriate documented governance structures.

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.

Service adheres to National Quality and Patient Safety and Patient safety strategy 2019–2024

Refer to National Incident Management System (NIMS)

See also Patient Safety Legislation and Advocacy

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

Evidence

- The service's operational policy that summarises safety and adverse event monitoring and reporting in endoscopy. Note: this must not be a 'groupwide' 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.
- Evidence should include documented process/ policy, evidence of meetings, and a summary of the themes and actions.

3.2: The endoscopist and practitioners meet before and after each list, for briefing and debriefing, to identify any potential risks or issues and ensure safe efficient practices during lists and effective learning.

Guidance

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

Evidence

- SOP for team brief and checks before each list.
- Example of pre-procedure brief and debriefs/ huddles.
- Protocol for patient assessment, risk assessment and management of procedure, including specific instructions.
- Examples of impact and learning, if applicable.
- Examples of risk management, assessments, incident reporting and staff awareness.

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3.3: A validated safety checklist is completed for every patient undergoing an endoscopic procedure.

Guidance

The World Health Organization (WHO) safe surgery checklist is recognised as a best practice model and can be adapted locally for endoscopy, incorporating its key elements.

Evidence

- Example use of organisation-approved, validated safety checklist (eg WHO safety checklist).
- WHO safe surgery checklist to be demonstrated as a minimum.

3.4: The requesting clinician assesses and documents a patient's fitness for oral bowel cleansing agents prior to distribution of the preparation.

Guidance

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

It is essential to verify that the patient is fit enough to undergo the procedure. This includes being able to take bowel preparation, lay flat and move for colonoscopy. In services where non-PEG based laxatives are used, protocols need to ensure that renal function has recently been assessed with appropriate advice given. Where the referring clinician is supported in this responsibility by appropriately trained pre-assessment nurses, it is essential that clear protocols exist.

Refer to the Endoscopy Programme Triage Guidance.

Evidence

- Evidence that the requesting clinician documents a patient's fitness for oral bowel cleansing agents prior to bowel preparation being dispensed.
- Evidence that the process for dispensing bowel preparation is in line with local pharmacy policy.

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3.5: There are core clinical protocols to support patient safety.

Guidance

See the BSG website / ESGE website for clinical guidelines.

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 patient's needs.

The service offers a full range of sedation techniques to maximise comfort, minimise patient anxiety and perform highly technical endoscopy in line with nationally accepted guidelines.

Evidence

The endoscopy clinical protocols for management of:

- diabetes
- anticoagulation including novel oral anticoagulants (NOACs)
- antiplatelet agents
- antibiotic use in patients undergoing endoscopy
- implantable devices in patients undergoing endoscopy
- safe prescribing and distribution of oral bowel preparation.

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

Guidance

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

Evidence

- A summary description of the leadership role and responsibilities for upper and lower GI bleeding.
- Data demonstrating that 75% of patients admitted with acute upper GI bleeding who are haemodynamically stable receive endoscopy within 24 hours of admission.
- Action plan supporting improvements where the guidelines have not been met.
- Minutes from the past year to show that out-of-hours GI bleeding has been assessed.

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3.7: 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.

Guidance

See the BSG acute upper GI bleed care bundle.

See the ESGE updates on endoscopic diagnosis and management of nonvariceal upper gastrointestinal hemorrhage.

There is currently no nationally agreed framework for the management of acute upper GI bleed. Each hospital region should develop their own acute upper GI bleed pathway through their regional executive officer (REO).

Acute services should have access to emergency endoscopy 24/7, as well as service design to support endoscopy for all appropriate patients with GI bleeds within 24 hours. Procedures must be performed by appropriately trained endoscopists and support staff. Out-of-hours work should be appropriately renumerated and occur as part of an organised rota. When endoscopy fails to stop bleeding, there should be 24-hour access to interventional radiography and surgery.

If services don't deliver, evidence of treat and transfer is required.

Evidence

Audits undertaken at least annually by clinical lead to confirm that procedures are performed appropriately and in a timely manner, and to monitor outcomes. Audit data should be presented at EUG, with an action plan implemented where indicated.

Procedure numbers

Number of procedures performed, indicating how many are performed out of hours (OOH).

Timings and appropriateness

All upper GI bleeds, where appropriate, undergo endoscopy within 24 hours of presentation. Data to support immediate access to OOH endoscopy. Use of Glasgow Blatchford score for pre-endoscopy risk stratification.

Intervention

Interventions undertaken (banding, gluing, injection, clips, thermal therapy) and their success (haemostasis, rebleeding) for each endoscopist.

Outcome

Number of patients requiring interventional radiology (IR) or surgery. Mortality and morbidity.

References

BSG-led multi-society consensus care bundle for early clinical management of acute upper GI bleeding.

Endoscopic diagnosis and management of non variceal upper GI bleed ESGE 2021.

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, including stabilisation of intraprocedural GI bleeds, and transfer arrangements.

Policy and SOP for the management of non-acute GI bleeds.

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

Guidance

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

In the non-acute sector, it is expected that every effort is made to identify this information.

Evidence

- Description of how deaths and unplanned admissions are identified and recorded (might include links with surrounding admitting hospitals, scheduled post procedure phone calls to patients, 30-day mortality and 8-day readmissions).
- Process for review and reporting of unplanned admissions related to endoscopy.
- List of cases identified through these processes and actions taken.



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4. Appropriateness and access

4.1: Referral guidelines are available for all procedures.

Guidance

It is recommended that all endoscopists agree guidelines for endoscopy and record these within the service's operational policy. Where feasible, the guidelines should be available through the service's website.

Refer to the endoscopy programme triage guidance and clinical position paper on endoscopy surveillance.

Evidence

Description in the endoscopy service's operational policy on:

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

4.2: There is a local protocol for vetting referrals for all endoscopic procedures by an appropriately trained individual. Inpatient endoscopy requests are triaged daily to prioritise clinically urgent cases.

Guidance

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

An appropriately trained individual can either be the endoscopist who performs that procedure or a triage nurse.

See triage guidance document.

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

Non-acute services should follow the agreed direct access criteria in any agreements.

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

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

SOPs should be based on best practice and national waiting times targets and standards, reviewed annually in accordance with new evidence and guidance.

Evidence

The service's operational policy or SOP defining:

- the service's vetting SOP, or the section within the operational policy that describes vetting practices, including outpatient and inpatient referrals, and the management of inappropriate referrals
- where surveillance is not routinely undertaken, a policy defining the management pathway and responsibility for patients requiring follow-up procedures (eg Barrett's, colonic polyps, gastric intestinal metaplasia (IM))
- examples of contracts/agreements with agreed direct access criteria
- examples of completed anonymised referrals – if referrals are undertaken electronically, this will be assessed during the site assessment.

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4.3: All surveillance procedures are clinically validated according to national guidance at least 3 months before the due date.

Guidance

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

Clinical validation may be conducted by an appropriately trained endoscopist.

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

Evidence

- A SOP(or SOPs) for upper and lower GI surveillance management that includes the process for clinical and administrative validation of surveillance cases.
- Administrative booking and escalation process for defined roles and responsibilities included in upper and lower GI surveillance SOPs.
- Administrative escalation process where timelines for booking are not met.

4.4: All appropriately vetted inpatient procedures (other than acute GI bleed) are performed within 3 working days.

Guidance

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

Clinical vetting may be conducted by an appropriately trained endoscopist.

Inpatients should be afforded a timely and appropriate high-quality endoscopy service to reduce length of stay and avoid harm. The timescales allow for the preparation of patients who require urgent colonoscopy. However, some patients may not need the procedure within this timescale and could be discharged to have it as an outpatient.

Evidence

The service's operational policy including:

- vetting process for all inpatient procedure referrals by an appropriately skilled endoscopist
- annual demand and activity data for inpatients
- tracking of timescales and assessment of procedural delays.

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

Guidance

Systems should be able to produce up-to-date waiting list and surveillance information. It is appreciated that many private 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.

Recovery plans should include details of areas to improve or target (ie workforce, capacity, alternative pathways etc).

Evidence

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 by nation.

If the service is not meeting waiting times, a detailed recovery plan with expected timescales for achieving compliance is needed, as well as data projection and performance tracking that shows improvements.

4.6: Monitoring of waits for outsourced patients is undertaken as per national guidance. There are policies and processes to commission, operationalise and monitor insourcing and outsourcing providers.

Guidance

Refer to the JAG outsourcing guidance.

See the National Treatment Purchase Fund (NTPF) for more guidance.

Evidence

Details of any outsourcing arrangements, including completed outsourcing checklist.

Details of any insourcing arrangements, including SOP.

Details of any outsourcing arrangements, including SOP.

Special attention must be paid to any outsourcing to a non-accredited provider, along with a risk assessment.

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4.7: There is an electronic patient-centred booking system that facilitates efficient booking and scheduling as well as capacity planning.

Guidance

This is defined as the patient having an informed choice of when to attend. It is expected that the service should reflect national and local recommended patient-centred booking practices.

Evidence

A description of the current electronic endoscopy scheduling tool.

A SOP that includes:

- current funded list provision by day/week, including type of list (service, training, screening, other)
- scheduling rules for all endoscopists, including points/cases expected per list
- booking and scheduling processes
- administrative pre-check for all patients
- the endoscopy administrative booking and scheduling SOP for new, planned, inpatient and surveillance patients.

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5. Consent and patient information

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

Guidance

Patient information, for all diagnostic and therapeutic procedures and pre-assessment, should explain potential discomfort to patients and the range of options for sedation. Information should be available in a range of formats and languages.

See the JAG quality and safety guidance.

Evidence

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

A range of procedural information leaflets and evidence that those with particular needs can receive information in a relevant format or language.

5.2: There is an endoscopy-specific policy for consent, including withdrawal of consent during a procedure (whether awake or under conscious sedation) in line with BSG and HSE (Health Service Executive) national consent policy.

Guidance

Must take into consideration procedure and patient-related factors.

The comfort of patients during the procedure is everyone's responsibility. The nursing team acts as the patient's advocate and should ensure that the procedure is paused and reviewed where there is distress.

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

Evidence

Written policy and evidence provided of policy in practice.

Withdrawal of consent policy.

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

Hospital consent policy.

The service's operational policy, including a section on consent in endoscopy, nurse-led consent 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.

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5.3: Appropriate patients are routinely pre-assessed in line with local policy and processes.

Guidance

There should be a SOP with clear inclusion and exclusion criteria, and a clearly documented process and risk stratification.

JAG expects consideration of patient characteristics, procedural risks and service requirements in determining the need for pre-assessment.

There should be a clear patient pathway supported by appropriately trained staff, with clear escalation, support and appropriate links with other services (anti-coagulation, cardiology, renal).

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 Anaesthesiologists (ASA) score of three or greater, where an underlying clinical condition or medications may make them more likely to have a complication (eg severe diverticulosis, patients on anticoagulants and patients having general anaesthesia).

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

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

Evidence

Policy or SOP for pre-assessment including indications for patient selection.

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6. Person-centred care

6.1: The endoscopy service establishes and implements policies and procedures to respect and protect clinical service users at all times during their treatment and/or care while on service premises.

Guidance

Services should adopt and follow their nation's policy.

See also JAG environment guidance.

The patient pathway SOP should summarise:

- privacy and dignity needs
- 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.

Evidence

Safeguarding policy for adults and children.

Patient Pathway SOP.

The service's operational policy must summarise anything specific to endoscopy and reference relevant regional and national policies/guidance.

Training updates for staff.

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.

6.2: Hospital-approved interpreter and translation services are always used unless the patient or carer chooses otherwise. If a hospital-approved service is not used, this is documented.

Guidance:

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

Evidence

- The service's operational policy, including a section on the use of interpreters, the use of family members or carers, and the range of other interpretation or translation services such as sign language.
- A section on the provision of these services throughout the patient journey.

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6.3: The endoscopy service has a documented procedure for the implementation and management of endoscopy service user booking systems.

Guidance

This is defined as the patient having an informed choice of when to attend and given the opportunity to agree a date within the framework of the HSE waiting list management policy. It is expected that the service should reflect national and local recommended patient-centred booking practices.

Evidence

There is an electronic scheduling system that supports patient booking.

The service's operational policy, including a section on:

- the room scheduling rota / capacity plan
- scheduling rules for all endoscopists, including points/cases expected per list
- booking and scheduling processes
- administrative pre-check for all patients
- patient-centred booking for new and surveillance patients.

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

Guidance:

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

Evidence

The service's operational policy, including a section on the process and timeline for administrative pre-checks and telephone pre-assessment and/or face-to-face pre-assessment.

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6.5: The clinical service documents person-centred treatment and/or care plans based on the needs of the individual clinical service user.

Guidance

As part of the patient admission process, it is expected that patients' needs and risks are assessed and documented. This must link to any pre-assessment requirements.

Evidence

Patient assessment/admission pathway or electronic assessment.

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

Guidance

Patient reports must be available and communicated to inpatient areas either in the patient record and/or electronically.

Results must be communicated to ward staff around the management of the patients.

Evidence

- Process where endoscopy is performed outside the unit and evidence that there is local access to the endoscopy reporting system to ensure timely reporting.

6.7: Patient comfort levels are monitored during and after the procedure.

Guidance

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.

Evidence

- Endoscopy operational policy, including a section on comfort monitoring and reporting in endoscopy.
- Patient feedback survey, results and action plan, which includes patient feedback on comfort.
- Evidence that both practitioner- and patient-reported levels are included in patient comfort monitoring and reporting.
- Evidence that NQAIS comfort score KPI data are routinely reviewed.

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6.8: Patients and carers are given both verbal and written information on the outcome of their procedure and any ongoing care. This will include a procedure-specific aftercare leaflet and a copy of the endoscopy report (or a patient-centred version).

Guidance

Leaflets should be appropriate to the patient population and specific to the service, and must be available for all diagnostic and therapeutic procedures performed.

Evidence

- 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.

6.9: There is access to a 24-hour service or contact number for patients or carers who have questions or experience problems following their procedure. There is an agreed protocol in place between the endoscopy service and the contact as to how the patient will be advised and managed.

Guidance

Patients should receive clear written instructions on how to obtain advice and support in the post-procedural period. Where feasible, this should be provided by the endoscopy service. 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 such as A&E. A call back system is a suitable alternative whereby the patient calls the switchboard and is called back by a member of the endoscopy team.

Evidence

- A provider in an acute setting should have 24-hour access to endoscopy nurses / endoscopists. This may be an on-call provision through the emergency department.
- In a private setting where procedures are performed and 24-hour medical cover exists, enquiries should be directed to the provider.
- Where higher-risk procedures such as ERCP or polypectomy >20mm occur, it is expected that a 24-hour helpline will exist.

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6.10: The service establishes and implements procedures that enable both patients and clinical service users to feedback on their experience within the endoscopy service.

Guidance

The service should actively encourage service users to provide feedback in confidence by using a variety of methods.

The service demonstrates that all clinical service users are informed of how to make comments on, and suggestions for, improvements.

The service demonstrates that concerns and complaints are captured, recorded and investigated.

Evidence

Evidence of a variety of feedback methods, including:

- family and friends
- endoscopy-specific patient survey
- focus groups.

Evidence of EUG and other meetings to show that outcomes are discussed at least annually. An action plan with a timed trajectory to address any issues. A method of feeding back to patients the outcome of surveys (ie you said we did).

6.11: The clinical service develops and implements an improvement plan with objectives and timescales in response to patient and clinical service user feedback, concerns and complaints.

Guidance

Action taken and improvements made by the service in response to patient and clinical service users' views are reported to staff members and made available in summary form to clinical service users and stakeholders on an annual basis.

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7. Performance and productivity

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

Guidance

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

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

Evidence

The service's operational policy that contains a section 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 rate)
- analysis of productivity results and recommendations discussed at EUG meeting
- weekly review of list productivity and performance.

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

Guidance

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

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

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

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

Evidence

Weekly review and planning meeting (ie 6-4-2 capacity planning that demonstrates review of schedules and optimisation of all lists).

Annual demand and capacity data/report, with plans to address any shortfalls in demand and capacity (eg business plan).

If the service is insourcing details of all insourcing arrangements.

If the service is outsourcing to another provider, the name of the provider.

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8. Results

8.1: There is a process for referring patients with a suspected or definitive cancer diagnosis to the multidisciplinary team (MDT) and a process for pathology to track malignant histology.

Guidance

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.

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, a suitably competent person must be available to respond and support patients.

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.

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

Evidence

The service's operational policy, including the processes for ongoing management of patients with suspected cancer, MDT reporting and patient access to support from relevant cancer specialist practitioners.

For the non-acute sector, the policy for referral to a local MDT team.

Policy for referral to a specialist practitioner who is competent to provide support to patients within 24 hours of their diagnosis.

SOP that documents the process to support patients with a cancer diagnosis.

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

Guidance

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

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 to the patient, the reason is recorded.

Evidence

Process for producing/printing reports.

If endoscopy is performed outside the unit, evidence that there is local access to the ERS to ensure timely reporting.

A service's operational policy that includes a section on aftercare, including:

- reports for patients and how they are given
- how patients are informed of the procedure outcome and next steps (eg pathology results).

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

Guidance

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

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

JAG expects histology to be reviewed before sending to a GP.

Evidence

The service's operational policy, including sections on:

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



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9. Patient environment and equipment

9.1: Decontamination equipment is tested and validated according to national guidance and action is taken on results which fall outside acceptable parameters.

Guidance

Decontamination equipment and associated machinery includes endoscope washer disinfectors (EWDs), reverse osmosis plants, endoscope storage cupboards etc. Testing and validation should be in line with national requirements, see HSE standards for decontamination.

Evidence

An 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.

Evidence of testing and validating of equipment is available.

9.2: The facilities and environment support service delivery.

Guidance:

The infrastructure and facilities in any area where GI endoscopy is undertaken meets 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.

There is a description of the facilities available for patients and referrers.

See Achieving a JAG compliant endoscopy environment (Republic of Ireland) guidance.

Evidence

Completed environment checklist (mandatory template 4), including an action plan to address deficit.

An infection control audit of the endoscopy and decontamination environments carried out by the local infection prevention team with a timed 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).

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9.3: There is a named decontamination manager and director for infection prevention and control (or equivalent). They are responsible for assessing and ensuring best practice in the endoscopy facility and environment management.

Guidance:

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

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

Evidence

The service's 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.

9.4: There is an annual review of equipment, including endoscopes, and a process for replacement. Systems maintain and quality assure equipment with corresponding records, including planning for replacement.

Guidance

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

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

Evidence

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.

The service's operational policy, including a section on:

- roles and responsibilities for reporting any kit or decontamination failure and management
- safety monitoring, reporting and escalation.

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10. Staffing the endoscopy service

10.1: The endoscopy service defines and has an agreed statement outlining the ethos, culture, professionalism responsibilities and discipline of the team, which is reviewed annually.

Guidance

The document should also describe the mission statement and objectives of the team. It should include a summary of what inclusivity means and how diversity is recognised and celebrated.

This includes visiting or temporary staff (eg agency staff, insourcing teams and staff who support the service or undertake only part of the patient journey).

Evidence

Documented guidance or a statement, outlining the ethos, culture, professionalism and discipline of how the team works together. This may form part of the region-wide policy but should be supported within the unit's operational policy with local objectives.

Description of the members of the team, and the responsibilities of both the core and wider team (operational or workforce policy or other document).

10.2: A matrix of clinical staff competencies is visible within the service.

Guidance

The matrix should include competencies for administrative and supporting nursing, and allied health professionals.

Local competencies for booking and scheduling, communication and planning should be under development or implemented to support administrative staff.

Evidence

Matrix of staff competencies for all procedures undertaken.

Admin competencies for all staff that support booking and scheduling practices.

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

Guidance

There are processes to recognise and share service pathway improvement within the team.

Evidence

Two sets of minutes each from administrative, nursing and EUG meetings (and any other relevant groups).

Examples of audits, project work, published papers or research work participated in.

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

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

Guidance

Smaller services may have alternatives such as team meetings or listening exercises.

Evidence requirements

Local survey of the endoscopy team (which includes administrative, portering and regular bank and agency staff) and service users (including endoscopists and referrers) about their perceptions on patient care, team leadership, team working and communication with patients and other professionals, and for how the service could be improved. This should be specific to the service and not hospital wide.

For smaller services, a team meeting discussing and noting feedback is acceptable:

- feedback in various forms from endoscopy users of the service (eg wards and GP referrers)
- minutes that show the staff survey has been discussed and actions planned if required
- quality improvement plans.

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

Guidance

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

Processes address performance issues through the service leads.

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

Appraisal outcomes should feed into workforce development plans.

The senior leadership team should match expected demand for the full range of endoscopy procedures against staff availability to provide endoscopy. Reduced list capacity because of training, full or partial retirement, competing demands on endoscopists' time – should be balanced against recruitment, training and insourcing/outsourcing. Procedures considered will depend on the service but may include OGD/colon, ERCP, EMR, and GI bleed, among others.

Evidence

Summary of skill mix needs for the service for all staff groups (including decontamination staff when decontamination is managed by the service).

The operational or workforce policy for the service, that includes sections on:

- recruitment and selection of staff
- induction and training
- mandatory training requirements
- an example of the duty roster showing how service needs are met
- how temporary staff (eg bank and agency) are used
- annual skill mix review
- sickness and absence rates
- workforce development plans in anticipation of future demands in the volume and type of future demand expected over the next year
- examples of endoscopy list schedules and rosters that identify bank and agency.

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

Guidance

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

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

Evidence

A summary of the annual workforce skill-mix review and the service's staffing needs, including the administrative team and any planned appointments required to support new work.

Meeting minutes or action plans that show how deficits and impact on the service will be addressed.

A review of recruitment and retention data including exit interviews.

Workforce development plans or business case.

Matrix of staff competencies for all procedures undertaken.

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

Guidance

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

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

Evidence

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.

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10.8: There is a nominated training lead who supports the endoscopy workforce, with policies and systems in place to ensure that the workforce is appropriately trained and competent for their role.

Guidance

Endoscopy workforce comprises admin, support staff and nursing staff.

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

The nominated trainer should have agreed proficiencies (eg mentor course/training the nurse trainer). There should be competency sign-off at each stage of their development, as well as final sign-off. This includes nursing staff, administrative staff, industry representatives, and professional and lay observers.

Evidence

A workforce, operational or organisational policy that describes:

- appraisals and staff development
- managing and supporting performance.

A workforce list summarising who:

- provides preceptorships and mentorships to new registered staff, existing staff and healthcare assistants (HCAs)
- provides training or teaching and assessing skills.

An operational, workforce policy or other training policy that covers the supervision of students, trainees and observers within the service.

A list of staff with training and assessment qualifications, and evidence of their maintenance.

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

Guidance

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

Evidence

A workforce list summary summarising:

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

JAG recommends an appropriate workforce competency framework such as the JETS Workforce competency framework.

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10.10: There is an effective appraisal system for the whole workforce, identifying learning needs and objectives.

Guidance

Appraisal should include other relevant information such as patient and staff complaints, 360 feedback and training needs analysis. There should be feedback mechanisms to provide medical and nursing staff with evidence to support the revalidation cycle (eg 360-degree appraisal, KPIs, training needs review), such as joint learning events, external training or providing accredited endoscopy-specific courses.

Appraisal and training needs anaylsis allow staff to identify ways of providing professional development.

Evidence

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

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

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

Guidance

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

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

Where new processes or equipment is introduced, there should be a training plan with identification of competencies met for all the whole workforce (eg change in ERS).

This includes administrative staff.

Evidence

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.

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

Guidance

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

In smaller units this role may be carried out by the training lead or equivalent role.

Evidence

Role description including responsibilities.

10.13: Service strongly encourages all healthcare professionals involved in the endoscopy patient pathway and assisting endoscopy procedures to participate in the JETS Workforce programme ENDO1 training course, including the pre-course requisite e-learning for health ENDO1 modules.

Guidance

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



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11. Endoscopist training

11.1: There is an endoscopy induction programme for all new endoscopy trainees that references all key quality indicators. A nominated local training lead has overall responsibility for the induction and appraisal of trainees. This is reviewed annually.

Guidance

There is appropriate recognised time in the training lead's job plan.

Evidence

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

This document, which should be available in electronic format, needs to include: details of key endoscopy staff and contact numbers, local induction process, appraisal, organisation of local training and training lead, JAG certification requirements, rules for independent practice and other useful training information and simulation resources.

11.2: The local training lead has attended a STEPS train the colonoscopy course trainer and has maintained and updated their trainer skills relevant to the procedures for which they act as a trainer. All trainers supervising dedicated training lists are registered on NQAIS, have attended a STEPS train the colonoscopy trainer course and have maintained and updated their trainer skills relevant to the procedures for which they act as a trainer.

Guidance

STEPS TtCT courses include generic endoscopy trainer courses or procedure-specific courses. It is not expected that a full TtCT course needs to be repeated every revalidation cycle. Maintenance of training skills can be evidenced through satisfactory trainee feedback. Updating of trainer skills can be achieved through any of the following:

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

Evidence

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

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11.3: There is an assessment of endoscopic skills conducted by the local training lead (or nominated deputy) for trainees seeking to perform procedures independently. This applies to all endoscopists coming into the hospital for the first time.

Guidance

The STEPS portfolio uses 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 then populate the trainee's personal development plan.

Evidence

Evidence of summative DOPS required for the JAG certification process.

11.4: Trainers and trainees use the STEPS portfolio to support training and evaluation.

Guidance

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

Refer to the competency model for skills training in GI endoscopy in Republic of Ireland.

Evidence

Evidence of review of NQAIS data from trainees and trainers.

Copies of completed DOPS and provisional approval documentation in trainee logbooks.

11.5: There is a nominated trainer for each endoscopy trainee.

Guidance

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

Evidence

A list of trainers who have undertaken a STEPS train the colonoscopy trainer course and can show evidence of maintaining and updating trainer skills relevant to the procedures for which they act as a trainer within the 5-year revalidation cycle.

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

Guidance

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

Evidence

Minutes where KPI data has been reviewed, demonstrating that the training lead regularly reviews NEQI 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).

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

Guidance

Refer to the competency model for skills training in GI endoscopy in Republic of Ireland.

Evidence

Evidence of trainee appraisal.

11.8: Feedback is obtained from endoscopy trainees on the availability of training support and the quality of the training environment. This, along with the delivery of endoscopy training, is reviewed in EUG or governance meetings that include trainee representation.

Guidance

Feedback should be sought from relevant areas and an improvement plan created where appropriate.

- This could be feedback from trainees or from a peer review.
- This may be supplemented with a separate report.
- Please ensure that the minutes uploaded are based on feedback from the last 12 months.
- This should include recommendations for improvement or sharing of good feedback.
- Please upload minutes where training provision and performance were discussed.
- Please upload minutes where trainers received feedback about their training skills, with recommendations, where required.

Evidence

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

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11.9: There are processes to maximise endoscopy trainees' exposure to emergency and urgent endoscopic procedures.

Guidance

Trainees identified as 'training in gastrointestinal haemostasis' will require evidence in their logbook of an agreed local mechanism to maximise exposure to gastrointestinal bleeding. Specialist trainees should have to have completed the STEPS haemostasis course by the end of their training.

Evidence

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

11.10: All endoscopy trainees have completed a mandatory STEPS basic skills courses or have a course booked.

Guidance

Refer to the competency model for skills training in GI endoscopy in Republic of Ireland.

Evidence

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

11.11: Endoscopy trainees have a minimum of 20 dedicated training lists annually that are planned at least 6 weeks in advance, in addition to ad hoc training opportunities. Training lists are coordinated by a dedicated member of staff.

Guidance

A dedicated training list is defined as 'a preplanned 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.

20 dedicated training lists or equivalent equates to around 160 OGDs or 80 colons (assuming 8 points per training list).

Evidence

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

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11.12: There is a policy for defining and monitoring practice of endoscopy trainees.

Guidance

Refer to the competency model for skills training in GI endoscopy in Republic of Ireland.

This will allow for a review of training goals and is important for continuity of training and maintenance of training standards.

Evidence

Policy for defining and monitoring independent practice of endoscopy trainees.

Evidence of review of trainee NQAIS data.

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

Evidence

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

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Further information regarding this document may be obtained from the JAG office at the Royal College of Physicians: **askjag@rcp.ac.uk**

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