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JAG Joint Advisory Group on GI Endoscopy

JAG accreditation
Global rating scale (GRS for services in the Republic of Ireland

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Introduction

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

The 2022 update to the GRS has been undertaken to:

> consider recent developments in endoscopy and the effects of the COVID-19 pandemic

> have a greater focus on outcomes, to demonstrate the measurable and tangible improvements that the standards deliver

> refine the standards where possible to make it easier for endoscopy services to benchmark practice

> absorb the quality assurance standards (used during service assessment) back into the GRS standards, to simplify the process for services gaining accreditation.

This document contains the GRS standards, guidance and accreditation evidence requirements for all adult services in the Republic of Ireland.

Some standards may not be relevant where a service is not delivered (for example, providing an inpatient service); endoscopy services can mark this as non-applicable where appropriate

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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. Each standard is given one of three levels:

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

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

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

The evidence

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

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

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1. Leadership and organisation

C 1.1: There is a defined leadership and governance structure with clinical, nursing, and managerial lead roles. The clinical lead should be facilitated to carry out their role.

Guidance

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

Evidence requirements

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

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

Guidance

The service description should be available in written or electronic format for patients and their carers and healthcare professionals.

Evidence requirements

- A summary description of the service for referrers, patients, and their carers.
  - Paper information
  - Website information

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

This would normally be the responsibility of the Endoscopy User Group (EUG). The list of audits should include review of NQAIS data (see National GI Endoscopy quality improvement guidelines) and other audits, including those of patient experience and staff satisfaction.

See Endoscopy Programme ShareFile.

Evidence requirements

- A documented annual audit plan for the service. This should include named leads for all key audits and clear timescales for audit completion. This should include quality and other audits.

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

Guidance

This includes a NQAIS-compliant endoscopy reporting system and other data capture systems for productivity.

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

2. Safety

C 2.1: Adverse events and key safety indicators are recorded, monitored and acted upon. Key safety indicators and auditable outcomes as defined by the National GI Endoscopy quality improvement guidelines are available in written and electronic form for procedures carried out in the service.

Guidance

Refer to the key performance indicators for endoscopy as outlined in the National GI Endoscopy Quality Improvement guidelines.

The service uses the agreed hospital adverse events management system.

Evidence requirements

- A service operational policy that summarises:
  - Safety/adverse event monitoring and reporting in endoscopy
  - Risk management and escalation processes in the organisation
- Evidence to support that the endoscopy team uses a validated safety checklist e.g. (WHO) safe surgery checklist.
- The terms of references and standard agenda template for the EUG.
- EUG minutes showing evidence of adverse events and audit reviews with agreed actions and learning from events.

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

Guidance

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

Evidence requirements

- Example use of organisation approved validated safety checklist (e.g. (WHO) safe surgery checklist).

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C 2.3: Patient's fitness for oral bowel cleansing agents is assessed and documented where appropriate.

Guidance

Refer to the Endoscopy Programme Triage Guidance.

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

See the BSG /ESGE websites for clinical guidelines.

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

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

Evidence requirements

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

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

Guidance

While no standards for the management of acute upper GI bleeding are in place in Ireland, The National Institute for Health and Care Excellence (NICE) has a set of quality statements to support an acute upper gastrointestinal bleeding quality standard.

Evidence requirements

- Policy and SOP for the management of GI bleeds, i.e. major haemorrhage policy (for services without an out-of-hours bleed service this includes immediate action and transfer arrangements).
- For services that provide an out-of-hours bleed service:
  - Data to support that 75% of patients admitted with acute upper GI bleeding who are haemodynamically stable receive endoscopy within 24 hours of admission
  - Data to support that 50% of the quality measures in the 2016 NICE guidelines for acute upper gastrointestinal bleeding have been met.
  - Minutes from the last year to show that out-of-hours GI bleeding has been assessed, preferably against the NICE guidelines.
  - Risk register and mitigation plan

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

Guidance

Outcomes of reviews should be reported through EUG/governance meetings. In the non-acute sector it is expected that every effort is made to identify this information.

Evidence requirements

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

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3. Comfort

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

Guidance

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

Evidence requirements

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

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

Guidance

The comfort of patients during the procedure is everyone's responsibility. The nursing team has a role to act as the patient's advocate and ensure that the procedure is paused and reviewed where is there is distress. Colonoscopy comfort scores should be jointly agreed between endoscopist and nurse.

Refer to the National GI Endoscopy Quality Improvement guidelines.

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Reference JAG guidance on managing endoscopist underperformance
for further information.

Evidence requirements

- NQAIS endoscopy quarterly reports highlighting individualised endoscopists' 'anonymised' data on patient comfort level and other NEQI quality standards. These should be fedback to individual endoscopists at least twice per year.
- JAG mandatory templates (mandatory template 1 and 2) to be used for uploading performance data to the JAG website (not individual endoscopist NQAIS reports).
- The service has a policy and process for supporting endoscopists whose patient comfort scores fall below agreed levels, including action and review timescales.

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

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A **3.6: The service is able to offer a full range of sedation techniques to maximise comfort, minimise patient anxiety and perform highly technical endoscopy. This should include access to general anaesthesia if required. Anaesthesia should be administered under the supervision of an anaesthetic doctor.**

Guidance

Local guidance on sedation should be in line with the National GI Endoscopy Quality Improvement guidelines.

Evidence

The service has a clinical pathway at a local and group level to address the management of patients who require general anaesthesia.

4. Quality

C 4.1: Key quality indicators and auditable outcomes defined by the National GI Endoscopy Quality Improvement guidelines for the procedures performed in the service are available in the department.

Guidance

The specific key performance indicated that require continuous monitoring are defined in National GI Endoscopy Quality Improvement guidelines for the Implementation of a National GI Endoscopy Quality Improvement Programme.

Evidence requirements

- Evidence that NQAIS data is reviewed routinely at EUG.
- In year EUG minutes showing evidence of audit feedback and agreed action plans (minimum 2 x sets).

B 4.2: Individual endoscopists are given feedback on their procedure KPIs at least two times per year.

Guidance

This includes all endoscopists who are working in the service and should include locums who are employed on contracts. New locums are expected to provide their KPI data and be observed scoping. JAG would expect that any new endoscopist is assessed at least once to assess competence and familiarise with equipment etc.

Evidence requirements

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

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C 4.3: The service has clear guidance on managing endoscopist performance and the action required if levels are not achieved and maintained.

Guidance

The service should establish clear guidance which identifies a process of review and discussion performance management, within a clear framework of decisions, action and escalation, which protects the safety and quality of the patients' endoscopy experience. It is the responsibility of the service clinical lead and Hospital Group Clinical Lead to review performance and action in line with the organisation's and national guidance in a timely manner.

Evidence requirements

- A summary of the systems and reporting processes that are in place to monitor the auditable outcomes and quality standards for endoscopy. Services are expected to complete those that apply to their service.
- In year EUG minutes showing evidence of audit feedback and agreed action plans (minimum 2 x sets).
- Evidence that Individual endoscopists are given feedback on their procedure key performance indicators at least 2x/year, and audits of their late outcomes at least 1x/year.

B 4.4: An endoscopy reporting system (ERS) captures immediate procedural and performance data. The ERS uploads GI endoscopy procedures to the National Quality Assurance Improvement System (NQAIS).

Guidance

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

See the National GI Endoscopy Quality Improvement Programme website.

Evidence

- Evidence of NEQI programme participation.

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B 4.5: The service collects data on inpatients who undergo endoscopy.

Guidance

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

Evidence requirements

- EUG minutes showing a review of relevant inpatient procedures and any actions arising.

B 4.6: All endoscopy procedures which take place outside the endoscopy service (e.g. in the theatre or intensive care unit (ICU)) are captured on the ERS.

Guidance

For endoscopy performed outside the endoscopy unit the report should be uploaded to the ERS to allow NQAIS endoscopy data collection.

Evidence requirements

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

5. Appropriateness

C 5.1: There are referral guidelines available for all diagnostic procedures in an accessible form.

Guidance

It is recommended that all endoscopists agree guidelines for endoscopy and that these are recorded in an operational policy for the service and should be available through website where feasible.

Refer to Endoscopy Programme triage guidance and also clinical position paper on endoscopy surveillance.

Evidence

- Description in the endoscopy service operational policy on:
  - A summary of processes for referrals
  - Guidelines used for surveillance addition/ selection
  - Type of services offered e.g. eg direct access.

C 5.2: There is a local policy for triage and vetting of all referrals.

Guidance

It is recommended that all endoscopists agree the triage and vetting policy for endoscopy. This policy should be reflected in the operational policy for the service.

Refer to Endoscopy Programme triage guidance and also clinical position paper on endoscopy surveillance.

Evidence requirements

- Description in the endoscopy service operational policy on:
  - Triage and vetting practices including outpatients and inpatient referrals
  - The process for validation of surveillance cases

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C 5.3: Endoscopy referral forms have sufficient clinical information to permit vetting of the appropriateness of the referral against guidelines.

Guidance

Referral forms can be paper or electronic.
Refer to specialist endoscopy Healthlink form.

Evidence requirements

- Agreed referral guidelines.
- Description in the endoscopy service operational policy on:
  - A summary of processes for referrals
  - Guidelines used for surveillance addition/selection

B 5.4: All surveillance procedures are validated clerically and clinically according to the current national guidance at least 2 months prior to the due date.

Guidance

Patients should be advised that in several years' time there may be a very good reason why their procedure has been cancelled or deferred for a longer period (e.g. new surveillance interval guidelines).

Refer to the Endoscopy Programme's clinical position paper on endoscopy surveillance.

Evidence requirements

- Description in the endoscopy service operational policy on:
  - Triage and vetting practices including outpatients and inpatient referrals
  - The process for validation of surveillance cases.

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B 5.5: The triage and vetting process is reviewed annually, and action plans are created to address any issues.

Guidance

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

Evidence requirements

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

6. Results

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

Evidence requirements

- Confirmation of the endoscopy reporting system for the service and a copy of an anonymised endoscopy report.

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

There should be a process for determining at the time of the endoscopy whether a referrer should be sent additional information. The endoscopist who has performed the procedure may be best placed to do this as they have specialist knowledge to interpret the results and determine further actions. If the patient has a planned outpatient appointment to review the endoscopy and pathology report, then this would fall outside this measure.

Evidence requirements

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

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B 6.6: The service can demonstrate a pathway to support patients with a new cancer diagnosis.

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 relevant clinician within one working day of the procedure so they can contact the patient. If a CNS is not available due to workforce gaps or other reasons, then a suitably competent person must be available to respond and support patients.

Evidence requirements

- SOP to support patients with a cancer diagnosis.

7. Respect and dignity

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

Guidance

This should include how the endoscopy service provides a comprehensive service to all patients irrespective of gender, ethnicity, disability, age, sexual orientation, religion, beliefs, gender reassignment, pregnancy and maternity, or marital or civil partnership status. Examples of how respect and dignity might be applied in practice in endoscopy include: > staff introductions, name badges, interpretation and translation policy (to ensure that patients and carers whose first language is not English get the same level of service as others) > patient information including pictures and sign language > dementia-friendly signs > privacy curtains/ clips in toilets and bathrooms and some examination rooms > side-tying gowns, larger size wheelchairs/ trolleys, flashing vibrating devices to alert hard of hearing patients. See the JAG environment guidance.

Evidence requirements

- The service operational policy, including sections on:
  - Equality and diversity
  - The patient pathway and privacy and dignity needs
  - Confidentiality
  - Security procedure
  - Supporting patients with mental or physical disabilities or additional learning needs
  - Supporting transgender patients
  - Meeting the nation-specific requirements for both gender and pre-/post- procedure segregation
  - Access to a quiet room for any clinical conversations to be held in private
- SOP's and risk assessment of changes made to the environment and pathway to maintain patient safety, privacy and respect in light of COVID-19.

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

Guidance

There should be a specific description of how vulnerable patients are cared for within the service and this ideally should be contained within the service's operational policy.

Evidence requirements

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

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C 7.3: There is a nominated Dignity Champion within the service.

Guidance

A Dignity Champion challenges disrespectful behaviour and acts as a role model by treating other people with respect, particularly those who are vulnerable; speaks up about dignity to improve the way that services are organised and delivered; influences and informs colleagues; and listens to and understands the views and experiences of patients.

Evidence requirements

- Description in the endoscopy service. operational policy on staff responsibilities for privacy and dignity.

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

Guidance

Communication methods and approaches will be different for each service and therefore must reflect both the needs of patients and the service, e.g. website, written information and specialised communication such as pictures. See 7.1.

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

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

Evidence requirements

- Patient involvement strategy for the endoscopy service (i.e. 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 (e.g. friends and family test or other). Summary of results and actions feedback at relevant meetings.
- EUG minutes showing evidence of patient survey feedback with agreed action plans.

8. Consent and patient information

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

Guidance

See 7.1 and 7.4

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

Evidence requirements

- A summary list of all patient information with dates of review.
- The service operation policy including a section on consent in endoscopy and withdrawal of consent (this may be a separate SOP).
- At least three examples of patient information, ideally colonoscopy, gastroscopy and flexi sigmoidoscopy (and ERCP if undertaken).
- Alternative patient information options to address language and learning needs.

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

Evidence requirements

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

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C

8.3: The service requires a patient's fitness for oral bowel cleansing agents to be documented where possible by the requesting clinician prior to bowel preparation being dispensed.

Guidance

The referrer needs to verify that their patient is fit enough to undergo the procedure. This includes being able to take bowel preparation, to lay flat and move for colonoscopy. In services where non-PEG based laxatives are used, protocols need to be in place to ensure renal function has recently been assessed with appropriate advice given.

Evidence requirements

- Evidence to support that a patient's fitness for oral bowel cleansing agents is documented by the requesting clinician prior to bowel prep being dispensed.

C

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

Evidence requirements

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

C

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

Guidance

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.

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

This activity should be included in the EUG or equivalent.

Evidence requirements

- EUG meeting minutes or equivelant.
- See 1.5.

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

Guidance

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

Evidence requirements

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

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9. Patient environment and equipment

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

Guidance

The service is advised to review the environment guidance document, available on the JAG website.

Evidence requirements

- A description of the facilities (outpatient and inpatient) available to support the service. The separate environment checklist must be completed annually and uploaded.
- The operational policy for the service including a section on accommodation and those with particular needs.
- The operational policy for the service endoscopy if applicable.

C 9.2: Decontamination equipment is tested and validated according to national guidance and action is taken on results which fall outside acceptable parameters.

Guidance

HSE Standards and Recommended Practices for Facility Design and Equipping of Endoscope Decontamination Units (2017).

Evidence requirements

- Evidence of testing and validating of equipment is available.
- The organisation's decontamination policy.
- SOPs for decontamination that support local practice and processes.

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C 9.3: The service has the facilities and environment to support delivery of the service..

Guidance

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

Evidence requirements

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

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

Guidance

The management lead for decontamination within endoscopy must fulfil the role and requirements as identified in the respective national guidance. Where decontamination is undertaken outside endoscopy, the nominated person must show how this links to the staff using the equipment within the endoscopy service. Where decontamination is overseen outside the unit, or by another authorised manager, procurement and management may fall within the remit of two people.

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

See the JAG environment guidance. The patient pathway/facilities will be examined during the site assessment.

Evidence requirements

- SOP or operational policy for unit access and restrictions.

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

Guidance

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

Evidence requirements

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

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10. Access and booking

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

Guidance

Patients at risk of breaching waiting times should be identified, escalated and offered appropriate dates for admission. JAG strongly recommends that referrals are pooled to support waiting times.

Refer to Endoscopy Programme triage guidance and IDPP protocol.

Evidence requirements

- The service operational policy, including a section on:
  - access for new patients
  - booking and scheduling rules > vetting
  - pooling > surveillance management
  - operational meetings
  - escalation processes
  - vetting
  - surveillance management
  - the process for determining and monitoring the capacity of each endoscopy list.
- Details of progress for validating patients against current surveillance guidelines.

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

Systems should be able to produce up-to-date waiting list and surveillance information.

Evidence requirements

- Endoscopy waiting list information and surveillance data for the service for the previous 3 months.
- If the service is not meeting waiting times due to COVID-19:
  - details of changes to triage, vetting and validation practices to reduce unnecessary referrals.
  - detailed recovery plan with expected timescales.

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B 10.6: There are policies and processes to commission, operationalise and monitor insourcing and outsourcing providers.

Guidance

Refer to the JAG insourcing and outsourcing guidance.

Evidence requirements

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

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

Guidance

Inpatients should be afforded a timely, appropriate and high-quality endoscopy service. The timescales allow for the preparation of patients for urgent colonoscopy. It is important to have robust vetting and patient assessment processes in place to ensure that only those patients that need the procedure in this timescale are treated.

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11. Productivity

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

Guidance

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

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

Evidence requirements

- The service 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 turn around audit, DNA and cancellation rate)
  - Analysis of productivity results and recommendations discussed at EUG meeting.

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

Guidance

Service teams need accurate demand and capacity information to deliver and plan services effectively. The frequency of unfilled lists should be reviewed. There should be active backfilling of lists and flexibility in endoscopist job plans to enable this.

Evidence requirements

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

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C 11.3: The service offers an administrative and nursing (if appropriate) pre-check for all patients before the date of the procedure to identify issues and to avoid late cancellations.

Guidance

An administrative pre-check or telephone pre-assessment is performed by booking/administrative staff to ensure that the service has the most up-to-date information about the patient's condition. Nurses may further support this. In some cases this check is led by nurses and this is down to local policy.

Evidence requirements

- Description in the endoscopy service operational policy including:
  - process for administrative pre checks OR telephone pre-assessment.
  - nurse involvement in checks (if applicable).

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

Guidance

See 11.1.

Evidence requirements

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

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12. Aftercare

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

Evidence requirements

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

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

Guidance

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.

Evidence requirements

- Description in the endoscopy service operational policy on aftercare including:
  - a 24 hour contact number for patients.
  - how patients are informed of the procedure outcome and next steps e.g. pathology results.
  - the process for informing patients of having a malignancy and support.

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

Evidence requirements

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

B 12.4: Patients and carers are told the outcome of the procedure and ongoing care plans, accompanied with a copy of the endoscopy report, where appropriate.

Guidance

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

Evidence requirements

- A service operational policy that includes a section on aftercare including:
  - reports for patients and how they are given.
  - how patients are informed of the procedure outcome and next steps, e.g. pathology results.

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13. Patient involvement

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Evidence requirements

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

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

Guidance

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

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

See 13.2.

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

A 13.6: Patients participate in developing and evaluating services.

Guidance

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

- Patient information and website
- Endoscopy User Group
- Patient interviews
- Review of patient feedback

Evidence requirements

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

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14. Teamwork

C

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

Guidance

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

Evidence requirements

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

C

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

Guidance

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

Evidence requirements

- Matrix of staff competencies for all procedures undertaken.

C

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

Evidence requirements

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

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

Guidance

See 2.5.

Evidence requirements

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

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

Evidence requirements

- Local survey of the endoscopy team (which includes all staff) and service users about their perceptions on patient care, team leadership, team working, and communication with patients and other professionals, and for how the service could be improved. This should be specific to the service and not hospital-wide. For smaller services a team meeting discussing and noting feedback is acceptable.
- Feedback in various forms from endoscopy users of the service, eg wards and GP referrers.
- Minutes that show the staff survey has been discussed and actions planned if required.
- Quality improvement plans.
- The above evidence should consider the effect of COVID-19 on staff wellbeing and staff absence, including an action plan with timescales where appropriate.

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

Guidance

The organisation should determine methods for reward.

Evidence requirements

- Examples of where teams and individuals have been acknowledged and rewarded.

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

Guidance

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

15. Workforce delivery

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Evidence requirements

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

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

Guidance

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

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

Evidence requirements

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

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

Evidence requirements

- Workforce development plans or business case.

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

Evidence requirements

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

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

Guidance

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

16. Professional development

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

Guidance

The training should cover medical, nursing and administrative workforces.

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

The nominated trainer should have nationally agreed proficiencies, e.g. mentor course / Train the Colonoscopy Trainer (TtCT). There should be competency sign off at each stage of their development and final sign off. This should follow nationally agreed training profiles.

Evidence requirements

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

C 16.4: There is an effective appraisal system for all staff, identifying learning needs and objectives.

Guidance

The appraisal process should be specific to the relevant profession and include all staff who are managed within the endoscopy service.

Appraisals can include information such as feedback from patient and staff surveys, 360-degree feedback, KPI data, training needs analysis etc.

Evidence requirements

- A summary of completed appraisals and personal development plans.

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

Guidance

There should be a needs analysis which includes external providers to support learning opportunities. Where the service requires specific learning to be undertaken, e.g. 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, e.g. change in ERS.

Evidence requirements

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

B 16.6: Processes address performance issues through the service leads

Guidance

All professionals should be provided with individual performance data sufficient to reliably inform their appraisal and revalidation requirements. Where poor performance has been identified, staff members should be supported through further training and education. If the staff member is still performing poorly, despite being given the necessary training and support, they should be manged through an agreed human resources process.

Evidence requirements

- An operational, workforce policy or other training policy which covers this scenario.

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

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

Guidance

Examples of these are a professional development nurse or clinical facilitator.

17. Environment, training, opportunities and development

C **17.1: Trainers and trainees use a portfolio to support training and evaluation. Trainers and trainees are registered and participate in the National GI Endoscopy quality improvement programme.**

Evidence requirements

- Evidence of review of NQAIS data from trainees and trainers.
- Copies of completed DOPS and provisional approval documentation in trainee logbooks.

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

Guidance

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

Evidence requirements

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

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

Guidance

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.

Evidence requirements

- A formal induction programme for trainees.
- Evidence would be schedule of the induction programme and signed attendance sheet.

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

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

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

Guidance

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

Evidence requirements

- EUG minutes to show training has been discussed to optimise opportunities for trainees.
- EUG minutes showing participation by trainees.

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

Guidance

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

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

Evidence requirements

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

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18. Trainer allocation and skills

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

Guidance

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

Evidence requirements

- 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.

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

Evidence requirements

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

C 18.3: The local training lead has attended a STEPS Train the Colonoscopy Trainer course and has maintained and updated trainer skills relevant to the procedures for which they act as a trainer.

Guidance

STEPS Train the Colonoscopy Trainer 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 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 STEPS course.
- attending an additional procedure specific TtCT course.
- enrolment on a formal medical education course (PCME, Diploma, MSc, PhD).

Evidence requirements

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

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

Guidance

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

Evidence requirements

- 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 (e.g. minutes where trainers have been reviewed and other communication such as emails to trainers with action points).

C 18.5: All trainers supervising dedicated training lists are registered on NQAIS, have attended a STEPS Train the Colonoscopy Trainer course and have maintained and updated trainer skills relevant to the procedures for which they act as a trainer.

Guidance

All trainers should maintain and develop their training skills

Evidence requirements

- Minutes where trainer performance is reviewed including faculty attendance at external courses.
- Trainer feedback for all trainers

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A **18.6:** **There is an annual direct observation of training skills assessment for all endoscopy trainers.**

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

Guidance

Unit training leads should liaise with group clinical lead and national training committee to support training faculty development.

19. Assessment and appraisal

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

Guidance

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

Evidence requirements

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

C 19.2: All endoscopy trainee activity is recorded.

Guidance

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

Evidence requirements

- Evidence that all endoscopy trainee activity is recorded.

C 19.3: There is an appraisal for all trainees commencing their training to identify their learning needs.

Guidance

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

Evidence requirements

- Evidence of endoscopy trainee appraisals completed and recorded

C 19.4: There is an assessment of endoscopic skills conducted by the local training lead (or nominated deputy) for trainees seeking to perform procedures independently in accordance with the competency framework for GI Endoscopy training.

Guidance

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

Evidence requirements

- Evidence of summative DOPS.

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C 19.5: There is a policy for defining and monitoring independent practice of endoscopy trainees in accordance with the competency framework for GI Endoscopy training.

Guidance

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

Evidence requirements

- Evidence of review of trainee NQAIS data.
- Record of provisional approval and / or final certificate.

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

Evidence requirements

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

A 19.7: Endoscopy trainees have an appraisal with their trainer at least annually.

Guidance

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

Evidence requirements

- Evidence of trainee appraisal.
- Record of provisional approval and / or final certificate.

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

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

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

Please speak to your endoscopist for more information or contact **askjag@rcp.ac.uk**

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JAG Joint Advisory Group on GI Endoscopy