JAG Accreditation
2024 Standards review

Revised standards
Public consultation 2025

Effective from: 11 Febraury 2025
Review date: 31 March 2025

JAG accreditation standards review

About

This document contains the proposed new JAG accreditation standards, currently known as the global rating scale (GRS). Accreditation standards are reviewed every 5 years to ensure they remain relevant, up-to-date, and ensuring the highest standards in quality and care.

In 2024, JAG invited feedback on the current GRS. Feedback was received from endoscopy services and key stakeholders with the main message from services highligting a need to reduce burden. The following highlights the key themes from the feedback collected:

- Combine standards that are repetitive or requesting the same evidence requirements to reduce burden for services
- Many standards and/or evidence requirements need to be updated in order to reflect the latest BSG guidance
- Remove all mentions of COVID 19, no longer needed or feels irrelevant to services
- Standards and evidence requirements need to reflect the differences across the devolved nations
- Review of terminology needed to make clear which staff groups are being referred to in certain standards.

JAG leadership used feedback as a basis for a review of the standards and would now like feedback on the proposal. Currently, the GRS is made up of 19 domains and 139 individual standards, some of which are not applicable to all centres. JAG proposes the new structure as follows, containing 11 domains and 87 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 proposed changes still encompass the cruical elements the current GRS covers, but are more succinct without compromising quality. Where necessary, guidance has been updated to reflect national guidelines. Some standards still require guidance and evidence requirements as this is still a work in progress and not the final version.

The current GRS rates standards using ‘a’, ‘b’, ‘c’ with ‘a’ standards being considered exemplary practice but do not impact a services accreditation. The new standards have removed this scale, and services are required to meet all the standards in order to achieve accredited status. There are ‘not applicable’ options in the standards below but JAG acknolwedges in the final version there will be further ‘not applicable’ options to make the standards relevant for independent services and services who do not act as a training centre.

Consultation will remain open until 31st March to allow sufficient time for feedback to be collected. Based on feedback further changes will be implemented with the final standards being made publically available in the summer 2025. Once the new standards are live, a 6 month time period will be communicated for services working towards achieving accreditation, or working towards reaccreditation.

Please use the online form to provide feedback on the standards. If you have any questions regarding the new standards, or want to provide feedback and feel the form does not give you sufficient space to do so, please contact askJAG@rcp.ac.uk

JAG Standards

Domain	Standard	Guidance	Evidence requirements
1. Leadership and organisation	**1.1:** There is a defined leadership and governance structure with clinical, nursing and managerial lead roles, with protected time in their job plans.	The leadership team should invite staff feedback to assess their effectiveness, for example a 360-feedback process. Clinical lead: JAG expects that the clinical lead scopes within the unit. This will usually be a gastroenterologist or surgeon. This lead will oversee clinical quality and safety, contributing to EUG presentation and discussion and reviewing clinical KPIs including taking actions where required. The individual should have adequate protected time to fulfil the role. In a DGH with established governance 1PA might be appropriate. Within the independent sector, in a small department 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 could suffice. Management lead: Time commitments must reflect activities required to manage performance and the development of the service including insourcing, and JAG support. More than one role may support these functions.	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. Senior Clinical endoscopist with adequate experience and strong support from appro gastroenterologist or surgeon from same unit and/or trust
	1.2: There are defined operational, nursing and governance meetings within the service that support organisation and delivery.	The service should have a defined documented meeting structure that covers: • Management and performance including; waiting list and productivity	A description of the reporting governance and performance structure including that includes as a minimum:

		performance, weekly capacity planning, 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 compliance. This must be included even if decon 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.	• 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.	This should be a hospital document management system or locally devised system that identifies review dates and owners for all key endoscopy documents.	Evidence of a system of document management including owners and dates of review for all key documents.
	1.4: There is an annual audit plan for the service with named leads and timescales.	**See the** JAG quality and safety guidance.	Annual rolling audit plan including named leads and timescales (this should include clinical and other audits, ie patient and staff). (JAG to provide template)
	1.5: The service has internal adequate technical support for data, audits and quality assurance to operate and improve the service.	JAG expect to see clear roles in quality assurance and audit support that reflect the needs of the service.	> Summary of managerial, administrative and technical support for the service and key functions including; Endoscopy reporting

			tools, BIU support for performance data, JAG QA support.
	1.6: The leadership team review and plan how to meet the service's strategic objectives annually, including for any service developments.	This is an opportunity to look back at what has been achieved. Services should consider how they engage with local populations and their representative organisations.	Annual review of the service strategy, objectives and resources including a plan that summarises deliverables for the service. Refer to other standards i.e 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, 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, and quality improvements, and research (where appropriate) sharing with other endoscopy services locally, regionally and/or nationally.	This could be attendance at learning events, visiting other services, sharing methodology etc. See the JAG website for learning opportunities, for example the safety case of the month.	Examples of innovation, sharing of quality improvements or research.
	1.8: The service has a 'green endoscopy' working group to reduce the environmental impact of the service and initiates at least one environmental initiative.	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	
	1.9: The service provides clear information about all endoscopy procedures.	Must include associated sites/insourcing providers. The service description and procedures offered should be available to referrers, patients and their carers, on a website. It should be in appropriate formats and languages for the local population, and be easily accessible. It should state if the service is a standalone service or operates on multiple sites, whether patients may be referred to other organisations, and any outsourcing and insourcing arrangements.	The description of the service including all linked or affiliated services, including relationships with other endoscopy services, patient groups, and services that share a common purpose. A summary description of the service for referrers, patients and their carers. This should be on a website and available in paper format. Feedback from referrers, patients and their carers.
	1.10: The service leadership team listens to the team and promotes the health and wellbeing of staff members.		Operational policy or SOP including section on support of team members. This can be a trust policy. Examples of how this is delivered (this may be discussed at assessment).
2. Quality	**2.1:** A matrix of endoscopists competencies for all procedures undertaken is visible within the service.	The matrix should include all endoscopist and supporting clinical staff competencies within the service.	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 comfort scores fall below agreed levels, the endoscopist's practice is reviewed by the clinical lead and/or governance committee.	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.	Use mandatory templates 1 and 2. Process to monitor the relevant quality standards for endoscopy. EUG minutes showing evidence of feedback from KPI audits and agreed action plans (2 x sets).

		JAG would expect that any new endoscopist is assessed at least once to assess competence and familiarise with equipment etc.	Process to assess the KPIs and competency of any new endoscopist. This should be for all grades including new consultants, trainees and, critically, locums. Evidence that individual endoscopists are given feedback on their procedure KPIs at least twice a year. This data should be linked with other information in the quality standards to form one report (eg comfort). Individualised endoscopists' 'anonymised' data on patient comfort level reports. This data should be linked with other information in the quality standards to form one report. Evidence of feedback to individual endoscopists at least twice per year.
	2.3: Individual endoscopists are given feedback on their safety outcomes at least annually.	The specific BSG safety outcomes that require review are described in the JAG quality and safety guidance. This is to include PCCRC, PEUGIC and procedural complications.	Evidence that individual endoscopists are given feedback on their safety outcomes at least annually, eg. PCCRC/PEUGIC Minutes that show that any PCCRC/PEUGIC that have arisen in the service (cancer diagnosed within 3 years after a colonoscopy/

			Gastroscopy has been performed) with action planned as required. Operational policy which describes how PCCRCs/PEUGIC are identified and acted upon.
	2.4: If individual endoscopist performance levels are not achieved, the endoscopy lead manages underperformance according to national guidance.	See JAG guidance on managing endoscopist underperformance.	The operational policy and process including a section on supporting endoscopist performance and escalation processes. Evidence of application of the process (if applied) and outcomes.
	2.5: An endoscopy reporting system (ERS) captures immediate procedural and performance data, uploading to NED compliant software.	This includes cases outside the endoscopy unit, such as emergency procedures, endoscopic retrograde cholangiopancreatography (ERCPs) performed in radiology and paediatric patients. JAG encourages services to be working towards the latest iteration of NED. See the NED website for advantages.	JAG will check whether the service uses NED compliant software, uploading to the latest iteration of NED and meets ongoing data validation_ requirements prior to booking an assessment.
	2.6: The service collects data of all 'off unit' GI endoscopy that occurs in the organisation and captures this on the ERS.	This does not usually apply if the service does not undertake endoscopy outside the main unit Where endoscopy is performed outside of the main unit, for example in outpatients, theatre or radiology, the service should identify patients and assess their indications and outcomes against BSG auditable outcomes and quality indicators.	The service operational policy including a section on ERS use and off unit endoscopy.
3. Safety	**3.1:** Endoscopy related incidents and key safety indicators are recorded, monitored	Robust system for identifying and recording monitoring acting upon and sharing adverse	The service operational policy that summarises safety/adverse event

	and acted upon with review every quarter by the senior leadership team. This is shared locally and nationally where appropriate.	events and key safety indicators. This is 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 British Society of Gastroenterology (BSG) outcomes that require monitoring are described in the JAG quality and safety guidance. Service adopts PSIRF principles, duty candour compliance, escalation and response to more serious incidents 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).	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. 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.	The focus of this should be to share safety learning and to identify potential patient, environment, kit, infection control and staffing issues.	Standard operating procedure (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, staff awareness.
	3.3: A validated safety checklist is completed for every patient undergoing an endoscopic procedure.	See the World Health Organization (WHO) safe surgery checklist. As recognised as best practice model. In addition to this, services might be using local processes such as GIRFT, NATSIPPS and NATSIPPS 2 which include the WHO checklist.	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.	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 renal function has recently been assessed with appropriate advice given. It is the responsibility of the accepting clinician to ensure that this happens.	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.
	3.5: There are core clinical protocols to support patient safety.	See the BSG 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 patients' needs.	The endoscopy clinical protocols for management of: • diabetes • anticoagulation including novel oral anticoagulants (NOACs) • antiplatelet agents

		The service is able to offer a full range of sedation techniques to maximise comfort, minimise patient anxiety and perform highly technical endoscopy in line with nationally accepted guidelines.	• 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.	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 gastrointestinal bleeding in adults quality standard.	A summary description of the leadership role and responsibilities for upper and lower GI bleeding. 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. Action plan to support improvements where the guidelines have not been met. Minutes from the last year to show that out-of-hours GI bleeding has been assessed, preferably against the NICE guidelines. Risk register and mitigation plan.

			See NHS guidance: Patient Safety Incident Response Framework
	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.	See the BSG acute upper GI bleed care bundle. See the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report on GI bleeds. Acute services should have access to emergency endoscopy 24/7 and 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.	Audit should be undertaken at least annually by clinical lead the aim being to reassure that procedures are performed appropriately in a timely manner and to monitor outcomes, Audit data should be presented at EUG and an action plan implemented where indicated.
	3.8: There is a process for identifying, reviewing and reporting deaths and unplanned admissions related to endoscopy.	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. Services should conduct a patient safety review of any cases that they are made aware of.	> Policy and SOP for the management of GI bleeds, ie major haemorrhage policy (for services without an out-of-hours bleed service this includes immediate action and transfer arrangements). > Policy and SOP for the management of non-cute GI bleeds > Policies should include how reports are reviewed and who is responsible for reviewing them.

4. Appropriateness and access	**4.1:** Referral guidelines are available for all procedures.	The service should have one set of referral guidelines for all procedures which are referenced in the operational policy and are easily available through websites for referrers. All endoscopists should follow nationally accepted criteria (NICE, BSG).	Agreed service referral guidelines. The service operational policy including: • a summary of processes for referrals • guidelines 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 endoscopist who performs that procedure, unless 'straight to test' or RAS protocols exist. Inpatient endoscopy requests are triaged daily to prioritise clinically urgent cases.	A strong emphasis on vetting is essential to ensure that patients are on the correct pathways for diagnosis and treatment. In the non-acute sector, all services completing NHS contracts are expected to follow the agreed terms for vetting cases. Non acute services completing NHS contracts 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 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.	The service operational policy including: • Vetting practices including outpatients and inpatient referrals, and the management of inappropriate referrals. • the process for validation of surveillance cases. • 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). • Service vetting SOP or section in operational policy. • Examples of NHS contracts with agreed direct access criteria.

			• Service inpatient vetting SOP or section in operational policy. • Examples of completed anonymised referrals. If referrals are undertaken electronically, this will be assessed during the site assessment
	4.3: All surveillance procedures are clinically validated according to national guidance at least 3 months before the due date.	This does not apply if the service does not undertake surveillance procedures. Patients should be advised that their procedure may be cancelled or deferred in future (eg new surveillance interval guidelines).	Service vetting SOP or section in operational policy. Details of progress for validating patients against the 2019 surveillance guidelines (if guidelines are not completely implemented).
	4.4: All appropriately vetted inpatient procedures are performed within two working days.	This does not usually apply if the service does not have an inpatient service. Inpatients should be afforded a timely and appropriate, high-quality endoscopy service. The timescales allow for the preparation of patients for urgent colonoscopy. Patients may not need the procedure in this timescale and could be discharged to have it as an outpatient.	The service operational policy including: • vetting practices for inpatient procedures • demand and activity data for inpatients • tracking of timescales.
	4.5: The service adheres to waiting time criteria for routine, surveillance and urgent cancer procedures.	Systems should be able to produce up-to-date waiting list and surveillance information. It is appreciated that many independent hospitals do not have waiting lists and offer immediate access; however, there will still be a record or summary list of patients waiting to come in. Applies to day cases and inpatients.	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.

		Evidence of adherence to patients being seen within 48 hours.	If the service is not meeting waiting times. Details of changes to vetting and validation practices to reduce unnecessary referrals. Detailed recovery plan with expected timescales.
	4.6: Monitoring of waits for outsourced patients is undertaken as per national guidance. There are policies and processes to commission and operationalise outsourcing providers. **(n/a option)**	Refer to the JAG outsourcing guidance.	Details of any outsourcing arrangements, including completed outsourcing checklist (2020). Special attention must be paid to any outsourcing to a non-accredited provider and risk assessment.
	4.7: There is an electronic patient-centred booking system that facilitates efficient booking and scheduling as well as capacity planning.	This is defined as the patient having an informed choice of when to attend and given the opportunity to agree a date at the time of, or ideally within 72 hours of, the referral or decision to treat. It is expected that the service should reflect national and local recommended patient-centred booking practices.	> The service operational policy including a section on: • scheduling rules for all endoscopists, including points/cases expected per list • booking and scheduling processes • administrative pre-check for all patients • the service operational policy, including a section on patient-centred booking for new and surveillance patients.

5. Consent and patient information	**5.1:** 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).	Patient information, for both diagnostic and therapeutic procedures and pre-assessment should explain potential discomfort to patients and the range of options for sedation. See the JAG quality and safety guidance. 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.	The policy and process for patient comfort, monitoring and reporting in endoscopy. This can be included as part of the operational policy.
	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 GMC guidelines.	Must take into consideration procedure and patient related factors 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. Patients are supported if they become distressed or wish to stop the procedure.	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 operational policy including a section consent in endoscopy and withdrawal of consent (this may be a separate SOP). A process for high-risk and vulnerable groups, as defined by the service, and how they are supported with consent before the date of the procedure.

	5.3: Appropriate patients are routinely pre-assessed in line with local policy and processes.	SOP with inclusion and exclusion criteria, clear documented process, risk stratification. JAG expects consideration of patient characteristics, procedural risks and service requirements in determining 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 Anesthesiologists (ASA) score of 3 or greater where an underlying clinical condition or medications may make them more likely to have a complication, eg severe diverticulosis, patients on anticoagulants and patients having general anaesthesia. High-risk procedures include planned therapeutic oesophagogastroduodenoscopy (OGD), percutaneous endoscopic gastrostomy (PEG), endoscopic retrograde cholangiopancreatography (ERCP), planned endoscopic submucosal dissection (ESD) and	Policy or SOP for pre-assessment including indications for patient selection.

		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.	
6. Person centred care ***Respect, dignity and safeguarding***	**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.	Services should adopt and follow their nations policy. See also JAG environment guidance (in review). 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.	Safeguarding policy for adults and children. Patient Pathway SOP. The service operational policy must summarise anything specific to endoscopy and reference relevant trust polices. 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: The use of hospital approved interpreter services is always used unless it is the patient's (or carer's) choice. If used, this is documented.	It is the patient's choice if they wish to use their family or friends as interpreters. This should be confirmed by an interpreter (usually by phone) and documented in the patient's file.	The service operational policy, including a section on the use of interpreters including the use of family members or carers.
Appointments and admissions	**6.3:** The endoscopy service has a documented procedure for the implementation and management of endoscopy service user booking systems.	This is defined as the patient having an informed choice of when to attend and given the opportunity to agree a date at the time of, or ideally within 72 hours of, the referral or decision to treat. It is expected that the service should reflect national and local recommended patient-centred booking practices.	There is an electronic scheduling system that supports patient booking. The service 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.	This ensures that the service has the up- to-date information about the patient's condition and medications. It could include a telephone assessment and may be undertaken by	The service operational policy for: • process for administrative pre-checks and telephone

		administration staff and supported by practitioners, or led by practitioners. It may identify patients for pre assessment. This may be undertaken by administration staff and supported by practitioners, or led by practitioners.	pre-assessment and/or face to face pre-assessment.
Clinical care	**6.5:** The clinical service documents person-centred treatment and/or care plans, based on the needs of the individual clinical service user.	As part of the patient admission process it is expected that patient's needs, risks and specific needs are assessed and documented. This must link to any pre assessment requirements.	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.	Patient reports must be available and communicated to Inpatient areas either rin the patient record and/or electronically. Results must be communicated to ward staff around the management of the patients.	Process for endoscopy is preformed outside the unit, evidence that there is local access to the ERS to ensure timely reporting.
	6.7: Patients' comfort levels are monitored during and after the procedure.	A comfort assessment should cover all endoscopy procedures, irrespective of sedation level. It is the endoscopy practitioner'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 practitioner is the best judge of the level of discomfort. Sedation may also affect patients' perceptions of discomfort. Patients should also be asked directly about their pain and comfort levels during and after the procedure.	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.

Aftercare	**6.9:** Patients and carers are told the outcome of the procedure and ongoing care, accompanied with a procedure specific aftercare copy of the endoscopy report (or a patient-centred version). There are procedure-specific aftercare patient information leaflets for all procedures performed.	Leaflets should be appropriate to patient population and specific to the service.	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.
	6.10: 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.	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. A call back system is a suitable alternative whereby the patient the patient calls the switchboard and is called back by a member of the endoscopy team.	An NHS provider in an acute setting should have a 24-hour helpline with access to endoscopy nurses/endoscopists. Where low risk procedures are carried out in a community setting enquires during opening hours should come to the unit with concerned patients being directed towards 111 or A+E out of hours. 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.
Patient involvement	**6.11:** The service establishes and implements procedures that enable clinical service users to feed back their views on their experience within the endoscopy service confidentially.	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 servicve demonstrates that concerns and complaints are captured, recorded and investigated.	
	6.12: The clinical service develops and implements an improvement plan with objectives and timescales in response to clinical service user feedback, concerns and complaints.	Action taken and improvements made by the clinical service in response to clinical service users' views is reported to staff members and made available in summary form to clinical service users and stakeholders on an annual basis.	
7. Performance and productivity	**7.1:** Service productivity metrics are agreed, reviewed and acted upon.	The service should consider including as a minimum the following performance and productivity dataset: • overall/individual utilisation of lists • booked versus achieved points for each list • start and finish times audit • room turnaround audit • did not attend (DNA) and cancellation rates.	Summary of the service delivery model (eg hot/cold sites, three session days or weekend working) The service operational policy that contains sections on: • the productivity metrics for the service including performance and productivity data (overall/individual utilisation of lists, start and finish times audit, room turnaround audit, DNA and cancellation rates) • analysis of productivity results and recommendations discussed at EUG meeting.

	7.2: There is a regular review of demand, capacity and scheduling with key service leads.	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.	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.
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.	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 then 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	The service operational policy including the processes for ongoing management of patients with suspected cancer, including MDT reporting and patient access to support from relevant cancer specialist 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 patients within 24 hours of their diagnosis. SOP to support patients with a cancer diagnosis.

		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.	
	8.2: 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.	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, the reason is recorded.	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. A service operational policy that includes a section on aftercare including: • reports for patients and how they are given (refer to CQ 6.1 for process on printing) • how patients are informed of the procedure outcome and next steps, eg pathology results.
	8.3: There is a process for the responsibility of clinical actions resulting from the pathology reports. Pathology reports are accessible with no undue delay.	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.	The service operational policy including sections on: • who is responsible to receive, review and act on histology results

		If the patient has a planned outpatient appointment to review the endoscopy and pathology report, then this would fall outside this measure.	• 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.
9. Patient environment and equipment	**9.1:** UK: Decontamination equipment is tested and validated according to national guidance and action is taken on results which fall outside acceptable parameters. ROI: Guidelines for endoscope decontamination are available in the service in written and/or electronic form.	Decontamination equipment and associated machinery includes endoscope washer disinfectors (EWDs), reverse osmosis plants, endoscope storage cupboards etc. Testing and validation should be in line with national requirements, eg Choice framework for local policy and procedures 01-06 – Decontamination of flexible endoscopes: Testing methods ((cfPP01/06).	An in-year IHEEM audit report (mandatory template 5) completed and signed by an authorised engineer for decontamination (AED) with an action plan to resolve any identified issues. If decontamination is outsourced, evidence of meetings to ensure that the outsourcing arrangement, audits and issues are reviewed and acted upon. This includes the tracking and traceability of scopes. The organisation's decontamination policy. SOPs for decontamination that support local practice and processes.
	9.2: The facilities and environment support service delivery.	The infrastructure and facilities in any area where GI endoscopy is undertaken meets the specific needs of all patients (including	Completed environment checklist (mandatory template 4), 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 the JAG environment and equipment guidance (in review).	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 an action plan to resolve any issues (this could be an Infection Prevention Society (IPS) audit or a locally designed audit). SOPs for infection control practices and patient pathway management. Confirmation of procedure room ventilation air changes (annual check report).
	9.3: 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.	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.	The service operational policy, including a section on roles and responsibilities for the patient areas, decontamination processes and infection control, and health and safety in the service.
	9.4: 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.	This should include time to allow for planned preventative maintenance and a risk assessment of kit which isn’t replaced.	A matrix of endoscopes with maintenance contracts and checks, and plans for replacement. A planned preventative maintenance schedule and full service history

		This should include a risk assessment of kit if not replaced.	records of all endoscopy equipment. The service operational policy, including a section on: • roles and responsibilities for reporting any kit or decontamination failure and management • safety monitoring, reporting and escalation.
10. Staffing the endoscopy service	**10.1:** The endoscopy service defines and has an agreed statement publishes the ethos, culture, professionalism responsibilities and discipline of the team, which is reviewed annually.	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.	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).
	10.2: A matrix of staff competencies is visible within the service.	The matrix should include competencies for administrative and supporting nursing and allied health professionals.	Matrix of staff competencies for all procedures undertaken.
	10.3: All staff are involved in the development of the service and are aware of how this affects their roles and practice.	There are processes to recognise and share service pathway improvement within the team.	Two sets of minutes each from admin, nursing and EUG meetings (and any other relevant groups). Examples of audit, 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 are surveyed at least annually on their perceptions of service delivery and improvements. Learning is actioned and reviewed every 6 months to ensure progress.	For smaller services, may have alternatives such as team meetings, listening exercises.	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.
	10.5: Policies and systems ensure that there are sufficient nursing and administrative staff with an appropriate mix of skills to	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	Summary of skill mix needs for the service for all staff groups (including decontamination staff when decontamination is managed by

	allow rostering of staff to support the duration of the service activity.	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. 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 demand on endoscopist time on one hand and recruitment/training and insource/outsource on the other should be balanced. Procedures considered will depend on the service but might include OGD/colon, ERCP, EMR, GI bleed amongst others.	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, for the next year • examples of endoscopy list schedules and rosters that identify where bank and agency.
	10.6: 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.	This includes the 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.	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. Workforce development plans or business case.
	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.	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 administrative staff, all visiting staff, such as locums, and non-substantive staff, such as agency staff, staff from other areas and insourcing teams.	Induction and orientation pack based on endoscopy competencies and adapted to staff groups as required. Competency assessments for different grades of staff (including staff working in decontamination and out-of-hours services, ie theatre staff). Training needs analysis for substantive staff. Examples of clinical service specific education. Mandatory training schedule and compliance.
	10.8: There is a nominated training leads for those assisting with endoscopy and support staff with polices and systems that ensure the workforce is appropriately trained and competent.	Training should cover, nursing and administrative workforces. JAG strongly recommends the use of JETS WorkforceJETS Workforce to support competency development and training.	A workforce, operational or organisational policy that describes: • appraisals and staff development • managing and supporting performance

	10.9: All healthcare professionals involved in delivering direct patient care have demonstrable competencies relevant to their role.	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.	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.
	10.10: A nominated mentor/trainer observes and supervises workforce until identified competencies have been achieved to demonstrate safe, independent practice.	The nominated trainer should have nationally agreed proficiencies, eg mentor course / Training the Nurse Trainer. There should be competency sign off at each stage of their development and final sign off. This should follow nationally agreed training profiles. This includes nursing staff, administrative staff, industry representatives, and professional and lay observers.	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
	10.11: There is an effective appraisal system for all workforce, identifying learning needs and objectives.	Appraisal should include other relevant information such as patient and staff complaints, 360 feedback and training needs analysis. There should be feedback	Appraisal and training needs analysis allow the service to identify ways of providing professional development.

		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.	
	10.12: Staff have sufficient time and resource to meet their learning needs, including when new or replacement equipment is introduced.	There should be a needs analysis which includes external providers to support learning opportunities. Where the service requires specific learning to be undertaken, eg new starters, new procedural skills etc., this should be identified in job plans with outcomes and support required. Revalidation requirements should be identified and resourced within annual appraisals. Where new processes or equipment is introduced, there should be a training plan with identification of competencies met for all the workforce, eg change in ERS. This includes administrative staff.	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.
	10.13: Educational facilitators are attached to the team and support learning and development.	Examples of these are a professional development practitioner or clinical facilitator, for example JETS Workforce.	Role description including responsibilties.
	10.14: Service to demonstrate 10% (to increase to 25% in Oct 2025) of all healthcare professionals involved in the endoscopy patient pathway and assisting endoscopy procedures have completed the JETS Workforce programme ENDO1 training course, including the pre-course requisite e-learning for health ENDO1 modules.	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.	

11. Endoscopist training	**11.1:** There is an endoscopy induction programme for all new endoscopy trainees which references all key quality indicators. A nominated local training lead has overall responsibility for the induction and appraisal of trainees. This is reviewed annually.	See e-Learning for Healthcare for endoscopy induction e-learning. There is recognised time in the training leads job plan. Can deputise role if needed.	A summary description of the training lead role and responsibilities for the service including the time commitment allowed to support training leadership.
	11.2: The local training lead and all trainers supervising dedicated training lists are registered on JETS and have attended a JAG-approved endoscopy specific TTT course and maintained and updated trainer skills relevant to the procedures for which they act as a trainer.	JAG-approved TTT courses include generic endoscopy trainer courses or procedure-specific courses – it is not expected that a full TTT course needs to be repeated every revalidation cycle. Maintenance of training skill can be evidenced by satisfactory trainee feedback. Updating of trainer skills can be via any of the following: • acting as faculty trainer on a JAG-approved course • attending an additional procedure-specific TTT course • enrolment on a formal medical education course (PCME, Diploma, MSc, PhD). All trainers should maintain and develop their training skills. Examples of this include: • participation in and JETS feedback from faculty involvement on a JAG-approved endoscopy training course. • a TTT/TET/TCT/TGT style course performed within the revalidation cycle. • a formal medical education qualification, eg PCME, Diploma or MSc level course.	The training lead must have attended a course, or show evidence of having a course booked. All trainers have attended, or are scheduled to attend, an endoscopy specific JAG accredited TTT course.

		• deanery-related trainer skills course that may be transferable to endoscopy practice (CPD approved)	
	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. Applies to all endoscopists coming into the trust for the first time.	The JETS e-portfolio uses the Direct Observation of Procedure or Skills (DOPS) as the main trainee assessment tool. These can be completed during a training list and learning objectives can be set, which populate the trainee's personal development plan.	Evidence of summative DOPS required for the JAG certification process.
	11.4: Trainers and trainees use the JETS e-portfolio (or equivalent in ROI) to support training and evaluation.	The JETS e-portfolio enables the local training lead to plan and monitor the training lists provided in the unit.	
	11.5: There is a nominated trainer for each endoscopy trainee.	A description of the role of a local endoscopy training lead and requirements for sessional time to support the role is available on the JAG website.	A list of trainers who have undertaken a Training the Trainers: (RCP – TTT, TCT, TGT or RCS TTT) course and can show evidence of maintaining and updating trainer skills relevant to the procedures for which they act as a trainer within the 5-year revalidation cycle.
	11.6: Endoscopy trainers' performance is reviewed and actions taken to develop trainers.	This should include a review of trainee feedback and audited KPIs with the local training lead, and may include an action plan for improvement. JETS will be examined with trainers during the site assessment.	Minutes where KPI data has been reviewed, demonstrating that the training lead regularly reviews BSG quality and safety indicators for all endoscopy trainers. Evidence of feedback and discussion (eg minutes where trainers have been reviewed and other communication such as emails to trainers with action points).
	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.	There is an appraisal completed in the JETS e-portfolio for all trainees commencing their training to identify their learning needs.	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 which include trainee representation.	Feedback should be gained from relevant areas (such as JETS and an annual training survey) and an improvement plan created where appropriate. The JETS e-portfolio supports trainee feedback on the quality of the training received on any training list. • 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. • Trainees should have a minimum of 20 dedicated training lists per year.	Minutes to show training has been discussed to optimise opportunities for trainees.
	11.9: There are processes to maximise endoscopy trainees exposure to emergency and urgent endoscopic procedures.	Trainees identified as 'training in gastrointestinal haemostasis' will require evidence in JETS of an agreed local mechanism to maximise exposure to gastrointestinal bleeding.	Process that ensures endoscopy trainees' exposure to emergency and urgent endoscopic procedures detailed within training policy.

	11.10: All endoscopy trainees have completed a mandatory JAG basic skills courses or have a course booked.		Evidence that all endoscopy trainees have completed or booked a basic skills course.
	11.11: 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. Training lists are coordinated by a dedicated member of staff.	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. This should include details of, organisation of local training and training lead. 20 dedicated training lists equates to around 160 OGDs or 80 colons (assuming 8 points per training list).	Training list allocation and schedule including ad hoc and dedicated lists (at an annual rate of at least 20 lists per year).
	11.12: There is a policy for defining and monitoring independent practice of endoscopy trainees.	The JETS e-portfolio documents progression of training and is transferable between services. This allows for review of training goals and is important for continuity of training and maintenance of training standards.	Policy for defining and monitoring independent practice of endoscopy trainees.
	11.13: There is a visible updated register within each procedure room of trainees allowed to perform specified procedures independently.		In-room competency register identifying trainees, training modality, and current level of supervision.

Document control	
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