Royal College of Physicians

JAG
Joint Advisory Group
on GI Endoscopy

JAG Paediatric Global Rating Scale (P-GRS)

Version for paediatric services in the UK

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Introduction

The Global Rating Scale (GRS) is a quality improvement tool designed to support endoscopy services to implement quality improvement and to meet the JAG quality assurance standards. This version has been developed to be specific to paediatric endoscopy services in the UK and is based on the GRS for adult UK endoscopy services. The GRS is maintained by JAG.

The GRS is made up of 19 standards, divided into four domains. Each standard has a number of measures which underpin it, which is assigned a level from D to A (described in the 'Levels' section below). Services are asked to answer 'yes' or 'no' to each measure using the webtool (www.thejag.org.uk). The measure answers then generate a score for the service for each standard.

Domain

Each domain refers to a broad aspect of care. There are four domains: clinical quality (quality and safety), quality of patient experience (customer care), workforce and training. All services are asked to complete the clinical quality, quality of patient experience and workforce domains. Only those offering endoscopy training are required to complete the training domain.

Clinical quality	Quality of patient experience
1. Leadership and organisation 2. Safety 3. Comfort 4. Quality 5. Appropriateness 6. Results	7. Respect and dignity 8. Consent process including patient information 9. Patient environment and equipment 10. Access and booking 11. Planning and productivity 12. Aftercare 13. Patient involvement
Workforce	**Training***
14. Teamwork 15. Workforce delivery 16. Professional development	17. Environment, training, opportunity and resources 18. Trainer allocation and skills 19. Assessment appraisal

*Training of endoscopists only needs to be completed by services offering training

Standards

The standards within each domain provide a more detailed picture of what the domain consists of. The standards are qualitatively different and therefore no standard is more or less important than another.

Measures

Measures are statements that are intended to be unambiguous. To assist services in answering appropriately, guidance statements have been added where necessary.

Levels

Levels create a more complete picture of the service by describing the different levels of achievement for a standard. These levels range from basic (D) to excellent (A). While scoring a standard with levels gives an accurate picture of performance, the scoring process can be subject to bias. To minimise bias measures are underpinned by national policy, guidelines and/or best practice guidance.

Services are required to score a Level B in all standards to apply for and maintain JAG accreditation.

Level	Summary	Description
A	Aspirational	Service is 'outward looking' with excellent adherence to requirements
B	Audit	Service is proactive to changes with a good adherence to requirements
C	Process	Service is reactive to changes with basic adherence to requirements
D	Policy	Service shows generally inadequate levels of adherence to requirements

Clinical quality

Standard 1: leadership and organisation

The purpose of this standard is to ensure that the service achieves an integrated and patient-focused endoscopy service. A service requires a clear structure for leadership, management and accountability. This standard ensures that the basic components of this structure are in place. Without these it will be impossible to deliver the standards in a cost-effective manner.

No	Measure	Guidance	Level
1.1	There is a designated Endoscopy Clinical Lead	The endoscopy clinical lead role is responsible for ensuring the clinical effectiveness, strategic planning and governance of the endoscopy service. All colleagues in team support the lead in this role.	D
1.2	There is a leadership team comprising clinical, nursing and managerial lead roles, each with defined responsibilities	There is a clear structure and clear lines of accountability within the team, and outside it to the organisation's senior management team. The leadership team is usually described as a triumvirate and should include at least medical, nursing and managerial/operational lead roles. If working with an adult team then embedded within that structure.	D
1.3	Clear information is available about the range of endoscopy procedures provided at this site and at all associated sites	Clear description of all endoscopic procedures on hospital website.	D
1.4	There is a defined governance structure for the endoscopy service with clear lines of accountability	This would normally be the Endoscopy Users Group or a recognised/alternative governance group.	C
1.5	There is an annual audit plan for the service with named leads and timescales for completion	The timetable should include the BSPGHAN clinical audits (see safety and quality standards) and other audits, including those of patient experience and staff satisfaction.	C
1.6	There is effective communication within the endoscopy service which supports the organisation and delivery of the service (e.g. operational and governance meetings)	The endoscopy service should have clear and effective communication structures and processes e.g. operational, and governance meetings, which show how alerts, changes and decisions are communicated such as MDT or endoscopy user group meetings etc.	C

1.7	The leadership team have protected time in their job plans and/or roles to lead and manage the service	This specifically applies to clinical, training and nurse leads.	C
1.8	There are defined processes and timescales to review and maintain all policies and standard operating procedures	Hospital process in place to review and update policies and SOP's.	C
1.9	The leadership team has sufficient managerial, administrative and technical support (such as IT) to organise and deliver the service effectively		B
1.10	The leadership team have access to timely and appropriate information on which to base operational and planning decisions	Information on capacity, demand, waiting times and booking processes is available to inform management decisions.	B
1.11	The leadership team review and set the service's strategic objectives on an annual basis and develops plans to achieve these objectives	Leaders develop annual operational plans within their area of responsibility, which are aligned to the paediatric gastroenterology team objectives.	B
1.12	The leadership team engages in sharing good practice with other endoscopy services locally, regionally or nationally	Sharing good practice could mean a number of approaches including attendance at learning events, visiting other services, sharing methodology etc.	A
1.13	There are systems in place to ensure that the leadership team seek and receive feedback about their performance on an annual basis	It is important that team leaders invite feedback from staff to assess the degree to which their leadership and management of the service is effective. This feedback can be at an individual level or for the leadership team. The staff survey could ask specific questions about the leadership of the service. All sources of feedback, including trainee and nurse feedback, should contribute to the review of leadership effectiveness.	A
1.14	There is an annual process in place to consider and plan resources for new service developments	An endoscopy service is encouraged to consider new developments and innovation annually; however the impact of any new innovations must be carefully considered and planned for.	A

Standard 2: safety

The purpose of this standard is to ensure that the service has processes in place to identify, respond to and learn from expected and unexpected adverse events.

No	Measure	Guidance	Level
2.1	There is a system for recording adverse events in the endoscopy service	Services are expected to monitor adverse events and outcomes applicable to their services (see BSPGHAN Quality and Safety Indicators document). The service should be able to show how these are managed and learned from.	D
2.2	There is routine use of a pre- and post-procedure safety checklist	Use of WHO safety checklist in all lists.	D
2.3	The leadership team reviews adverse events at least every 3 months	An endoscopy service is expected to use the hospital wide adverse events management system and show how these are managed and learned from This may involve discussion in mortality and morbidity meetings.	C
2.4	There are local policies or protocols for the management of diabetes, anticoagulation, antiplatelet use, antibiotic and implantable devices in patients undergoing endoscopy	There are local policies in place for management of diabetes. Advice from paediatric haematologist is sought for managing patients on anticoagulation, antiplatelet and implantable device. Advice from a microbiologist with paediatric experience is sought for antibiotic usage.	C
2.5	The endoscopist and the endoscopy nurses meet before each list to identify any potential problems, including high-risk patients or procedures, and to anticipate the need for equipment or accessories	Endoscopy teams meet before each list to identify potential problems including high-risk patients or procedures, staffing issues, requirements for equipment and accessories, and coordinating with endoscopy teams in parallel rooms. This is usually called a team briefing and ideally should happen with all core staff involved with endoscopy on that day.	C
2.6	Over 50% of patients admitted with acute upper gastrointestinal bleeding who are haemodynamically stable receive endoscopy, if appropriate within 24 hours of decision	Teams have access to emergency endoscopy theatres when required. Teams are advised to look at ESPGHAN/ ESGE guidance statements.	C
2.7	Patients with acute upper gastrointestinal bleeding undergo a risk assessment	Risk assessments include an appropriate clinical assessment by a senior member of the team.	C

2.8	A process is in place for identifying and reviewing all deaths occurring within 30 days of an endoscopic procedure and all unplanned admissions within 8 days of an endoscopic procedure	The endoscopy service is expected to review all safety matters including 30-day mortality and 8-day readmissions at agreed intervals as appropriate for the volume of work for that service. It is equally important to show how identified issues are managed and learned from and how the duty of candour is discharged.	B
2.9	Reviews of 30-day mortality include an assessment of the appropriateness of the procedure and any contribution of the procedure itself to the cause of death. Outcomes of reviews are reported through agreed hospital governance structures	The endoscopy service is expected to review all safety matters including 30-day mortality and 8-day readmissions at agreed intervals as appropriate for the volume of work for that service. It is equally important to show how identified issues are managed and learned from and how the duty of candour is discharged.	B
2.10	Actions required in response to learning from adverse events are implemented within three months of review	It is usual to see a hospital-wide adverse events management system and an endoscopy service is not only expected to use this but also show how near misses and adverse events are managed and learned from.	B
2.11	Over 75% of patients admitted with acute upper gastrointestinal bleeding who are haemodynamically stable receive endoscopy if appropriate within 24 hours of admission	Teams have access to emergency endoscopy theatres when required. Teams are advised to look at ESPGHAN/ ESGE guidance statements.	B
2.12	If there are resource constraints for responding to adverse events (e.g. 24/7 on-call bleed rotas) these are identified and the adverse event reported to appropriate senior management		B

Standard 3: comfort

The purpose of this standard is to ensure that the service implements and monitors systems to ensure that the comfort of patients is supported and respected throughout their contact with the endoscopy service.

No	Measure	Guidance	Level
3.1	Comfort level assessed post-procedure using pain assessment tools appropriate for age and understanding of child (paediatric appropriate pain scale)	A locally agreed paediatric appropriate pain scale is used.	D
3.2	Patients receive information ahead of time which provides a realistic description of the level of discomfort to be expected during the procedure (if under sedation)	This is not applicable for units performing procedures under GA.	C
3.3	Patient comfort scores (if under sedation) and/or incidence of post-procedure pain are reviewed at least 2x/year by the endoscopy leadership team and shared with individual endoscopists	This is not applicable for units performing procedures under GA.	C
3.4	If an endoscopist's patient comfort scores fall below agreed levels, the endoscopist is required to take remedial action and scores are reviewed again within 6 months (if under sedation)	This is not applicable for units performing procedures under GA.	B
3.5	If patient comfort levels do not reach acceptable levels after a remedial period, that individual's endoscopy practice is reviewed by the unit's clinical lead and/or provider governance committee (if procedure under sedation)	This is not applicable for units performing procedures under GA. For units performing procedures under sedation - feedback of comfort levels to endoscopists is important to reassure those who are causing relatively little discomfort, and to make those causing more discomfort aware of the possibility that they might be able to improve their technique or sedation practice.	A
3.6	The service is able to use CO2 insufflation		A
3.7	The service is able to provide N2O inhalation for all patients undergoing lower GI procedures if performing procedures under sedation	This is not applicable for units performing procedures under GA.	A

3.8	The service is able to offer a full range of sedation techniques to maximise comfort, minimise patient anxiety and perform highly technical endoscopy. This will include regular access to propofol based sedation and general anaesthesia. This is only relevant for a unit that performs procedures under sedation	A vast majority of paediatric units perform the procedures under GA and therefore will not be offering sedation. This is not applicable for units performing procedures under GA.	A

Standard 4: quality

The purpose of this standard is to ensure that the service implements and monitors systems to ensure the clinical and technical quality of all procedures.

No	Measure	Guidance	Level
4.1	Key quality indicators and auditable outcomes defined by BSPGHAN for the procedures performed in the service are available in the department in accessible form	Services are advised to look at this document and complete those that apply to their service.	D
4.2	Systems are in place for monitoring BSPGHAN auditable outcomes and quality standards for endoscopy	Services have an endoscopy reporting system and an annual endoscopy audit plan in place.	C
4.3	The BSPGHAN auditable outcomes and quality standards are reviewed on a regular basis	The service has an annual endoscopy audit plan which includes measures (auditable outcomes and quality standards) from the BSPGHAN quality and safety indicators document. Services are expected to audit against auditable outcomes and quality standards that apply to their service.	C
4.4	Individual endoscopists are given feedback on their outcomes and standards, at least 1x/year	Individual endoscopists should review their procedural KPIs at least two times per year with either the clinical lead for the service or a suitable other senior clinician. The service should establish clear guidance which identifies a process of review and discussion of such periods, within a clear framework of decisions, action and escalation, which protects the safety and quality of the patients' endoscopy experience.	C
4.5	The service has clear guidance on managing endoscopist performance and the action required if levels are not achieved and maintained	Hospital guidance on raising concerns around performance is followed and actions planned in a timely manner.	C
4.6	There is an endoscopy reporting system (ERS) in place to capture immediate procedural and performance data		B

4.7	Actions taken in response to poor performance by an endoscopist are reviewed within agreed timescales		B
4.8	If an endoscopist's performance does not reach acceptable levels after an agreed remedial period, the unit's clinical lead and provider governance committee reviews that individual's endoscopy practice.	The clinical lead is supported in this by appropriate Hospital processes which may involve the clinical or medical director	B
4.9	The ERS is able to communicate outcomes data to the National Endoscopy Database (NED)*	The NED is a project to automatically upload data from services' ERSs to a central database. This will facilitate quality assurance and benchmarking at a national level. Individual users and services will be able to access their own performance data. All ERS manufacturers, which are known to the JAG, are engaged with the NED project. A list of these is provided in the NED Key Facts document. If you have an alternative ERS provider, please add these to the unit information section of the GRS census or contact askjag@rcp.ac.uk. To answer 'yes' to this measure, the ERS used by your service must: • provide the necessary data to the NED and the data uploads from your service must be up to date. Attaining compliance will be facilitated by the ERS manufacturer and the NED project team in partnership with the service.	A

*Paediatric services are not expected to meet this measure until further notice.

Standard 5: appropriateness

The purpose of this standard is to ensure that the service implements and monitors systems to ensure appropriate and safe referrals for all procedures.

No	Measure	Guidance	Level
5.1	There are referral guidelines available for all diagnostic procedures in accessible form	Services are advised to look at the ESPGHAN/ ESGE guidance.	D
5.2	There is a local process for vetting referrals	Referrals are vetted by a paediatric endoscopist.	D
5.3	Referral Guidelines for other procedures have been agreed by all who perform those procedures	Paediatric endoscopists locally have agreed pathways/ SOP's.	C
5.4	All referrals from non-endoscopists within primary and secondary care are vetted by an endoscopist who performs that procedure, unless agreed straight to test protocols exist	Paediatric endoscopists vet all referrals and a local process in place for straight to endoscopy exists such as for coeliac disease.	C
5.5	Inpatient endoscopy requests are triaged to prioritise clinically urgent cases	Paediatric endoscopists triage inpatient urgent or elective referrals	C
5.6	Endoscopy referral forms have sufficient clinical information to permit vetting of the appropriateness of the referral against guidelines	Paediatric endoscopists use either endoscopy referral forms or clinic letters with adequate clinical information or a clinic consultation to guide the endoscopy decision making process	B
5.7	An audit of the vetting process is undertaken 1x/year and action plans are created if problems are identified		A

Standard 6: results

The purpose of this standard is to ensure that the service implements and monitors systems to ensure the clinical and technical quality of the interpretation of test results, and their reporting and communication.

No	Measure	Guidance	Level
6.1	All endoscopy reports are completed on the day of the procedure and include follow up details		D
6.2	Endoscopy reports for all in-patients are placed in the patient record before the patient leaves the department		D
6.3	Endoscopy reports/related information are sent to the patient's referring clinician within 24 hours of the procedure	This could be a standard discharge summary including information of the endoscopy procedure.	C
6.4	There are local processes in place to identify who endorses pathology reports when received by the service		B
6.5	If the endoscopist has responsibility for taking action or making recommendations based on pathology reports, that action is taken, or recommendations are dispatched within five working days of receipt of the report	If the patient has a planned outpatient appointment to review the endoscopy and the pathology report, then that would be an appropriate alternative.	B
6.6	If it is necessary for the referrer to receive additional information (usually in the form of pathology reports), this information is dispatched to the referrer within five working days of receipt of report		A

Quality of patient experience domain

Standard 7: respect and dignity

The purpose of this standard is to ensure that the service implements and monitors systems to ensure that the privacy, dignity and security of all patients are respected throughout their contact with the service

No	Measure	Guidance	Level
7.1	The service has access to a respect, dignity and security policy which includes the care of all children accessing the service	Staff needs to be familiar with and act in accordance with the Departmental Operational Policy for the children's endoscopy service that describes the patient's journey. This SOP should be supplemented with the child protection policy, privacy and dignity policy. Additional to this there will be an individualised nursing care plan. This will enable personalised care that meets the individual and cultural needs of children accessing the service.	D
7.2	There is a policy and process for safeguarding children and access to a child protection team if needed	Evidence (mandatory) that staff are trained and up-to-date with child protection training and thus act in accordance with the local child safeguarding and protection policies and Hospital policy, Hospital policy for managing risks associated with safeguarding children (see 7.1).	D
7.3	There are processes to identify the personal needs of all patients (background, culture and including vulnerable children)	Availability of SOP's, Pre assessment, care pathways and nursing care plans. This will enable personalised care that meets the individual and cultural needs for children accessing the service.	C
7.4	There is a range of communication methods and materials to ensure that patients are appropriately informed about what they should expect from the service (website, written information, specialised communication e.g. pictures)	Communication methods and approaches will be different for each service and therefore must reflect the needs the service allowing for family centred care. Patient information should be child friendly appropriate for age. With access to a website, written information and specialised communication such as a tablet to view pictures, videos and an opportunity to view feedback from other service users.	C

7.5	There are processes and training systems in place to ensure that all staff act with discretion and respect towards all patients, parents and carers	Training for staff may be organisation wide or bespoke for the service. New staff and equipment are integrated into the service supported by relevant education and training packages supported by monitoring and review systems to enhance the quality of care provided.	C
7.6	There are systems in place for any clinical conversations to be held in private	Staff to act in accordance with Hospital policy for Privacy & Dignity, NHS confidentiality code of Practice, access to separate room or area for private discussion.	C
7.7	The use of family and friends as interpreters is discouraged unless it is the patient's / parents/ guardian's choice to use them as interpreters. If the patient/parent/guardian exercises this choice it is documented in their file	Staff introductions, name badges, interpretation and translation policy in place (to ensure that patients and carers whose first language is not English get the same level of service as others), Access to Hospital system for accessing interpreter services, and Individualised care plan/pathway will identify personalised requirements for the individual and cultural needs of children accessing the service.	C
7.8	Patient-identifiable material is not openly displayed in areas accessible to patients, parents or carers	Staff awareness with regards to following the Data protection policy, NHS confidentiality code of Practice, Information Governance & Training.	B
7.9	Patients' privacy and dignity is adequately protected at each stage of their pathway supported by clear processes and staff understanding	Staff to act in accordance with Hospital policy for Privacy & Dignity. Professional code of conduct and provide personalised care that takes in to account each individual child wishes regarding each stage of their pathway regarding their own preparation and wearing of gowns and underwear. Universal accessible signs across hospital departments for toilets and bathrooms, privacy curtains in toilets and bathrooms and examination rooms.	B

Standard 8: consent process including patient information

The purpose of this standard is to ensure that the service implements and monitors systems to ensure that informed patient consent is obtained for each procedure.

No	Measure	Guidance	Level
8.1	There is a published patient information sheet for all procedures (diagnostic and therapeutic) performed in the department	Patient information should be factual, child friendly and appropriate for age. The patient information leaflets should be available in different formats via the website. Information should also be available in different languages.	D
8.2	There is accessible guidance within the service for consent including withdrawal of consent during an endoscopic procedure if performed under conscious sedation	Services should follow the GMC guidance for consent.[1] Also all paediatric services must follow the guidance in 0-18 years: guidance for all doctors, and in particular the section Making decisions (paragraphs 22–41).[2] Services follow the GMC consent guidance related to children and young people.	D
8.3	Signatures are obtained on a consent form from all parents, legal guardians or patients as appropriate	This standard is a legal requirement and should be directed using the above guidance.	C
8.4	All patients, parents or legal guardians are given an opportunity and sufficient time to ask questions about the procedure before consent is agreed and prior to the endoscopy by a professional trained in the consent process	Where possible this should be done during the initial consultation prior to listing for the procedure or at pre-assessment by the endoscopist or appropriately trained other.	C
8.5	High-risk' patients and their parents or legal guardians are informed of the additional risk, by the endoscopist carrying out the procedure, and there is a process to document this	Prior to the procedure any additional risk associated with the procedure should be discussed with the relevant others, which should be documented on the consent form and also in the patients' individualised care plan/pathway and/or medical records. The paediatric anaesthetic team will need to be informed prior to the procedure.	C

8.6	High-risk' patients are assessed before the date of the procedure to properly prepare them for procedures (and to avoid late cancellations)	There is a process in place to highlight high-risk patients to the endoscopy and the paediatric anaesthetic team - this will help to identify any special medical, nursing considerations/equipment needs.	C
8.7	The consent process for inpatients scheduled to have therapeutic procedures is commenced on the ward, either by the provision of procedure-specific information or by pre-assessment by the endoscopist or appropriately trained other	As per 8.2.	B
8.8	Non-compliance of any consent issue is recorded as an adverse event	If a deviation occurs, an adverse event (e.g. using an adverse event system such as Datix system) should be logged for review at an appropriate governance meeting.	B
8.9	Two-stage consent is performed for all procedures booked from clinic, with first stage consent taken in clinic, including explanation of risks of and alternatives to the procedure, and the risks of bowel preparation for colonoscopies	Immediately prior to the procedure a second review of the consent process should be carried out. This can be done by the endoscopist or appropriately trained other.	B
8.10	There is a process to review and update (as required) all patient information annually to reflect patient feedback and changes in practice or risks (covers website, printed information and other)		B
8.11	Consent for all in-patients is taken on the ward or as a minimum outside the procedure room		A
8.12	Appropriate patients are routinely pre-assessed, either by telephone or in person	There is a process in place for ensuring appropriate patients can be pre-assessed. Availability of SOP's, Pre assessment, care pathways and nursing care plans will facilitate this process. This will enable personalised care that meets the individual and cultural needs for children accessing the service.	A

Standard 9: patient environment and equipment

The purpose of this standard is to ensure that adequate resources are provided and used effectively to provide a safe, efficient, comfortable and accessible service. This is achieved through appropriate and adequate facilities (rooms and equipment) and the integration of sound business planning principles within the service.

No	Measure	Guidance	Level
9.1	Testing and validation of the Decontamination equipment and associated machinery is carried out according to national decontamination requirements and guidance and action is taken if necessary on results which fall outside the acceptable parameters	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 home nation requirements e.g. Choice framework for local policy and procedures 01-06 – Decontamination of flexible endoscopes: Testing methods ((cfPP01/06).	D
9.2	There is a service policy that describes access to the facilities and restrictions where appropriate	There are systems in place to ensure that all areas used by the service meet the specific needs of children and young people (including those with special needs) and staff.	D
9.3	There are systems in place to ensure that all areas used by the service meet the specific needs of the children undergoing endoscopy (including those with particular needs) and staff	The service is advised to review the separate environment supporting checklist.	C
9.4	The service implements and monitors systems to ensure that the facilities and environment support delivery of the endoscopy service. This includes annual completion of the endoscopy environment checklist	Decontamination assessment, yearly audits and action plans are required.	C
9.5	There is an endoscopy management lead responsible for the endoscopy facility(s) and environment management (includes decontamination)	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.	C

9.6	There is an endoscopy management lead responsible for the procurement and management of all endoscopy equipment and consumables (includes decontamination)	Where decontamination is overseen outside the unit, or by another authorised manager, procurement and management may fall within the remit of two people.	C
9.7	There is an annual authorised engineer report for decontamination	Decontamination assessment, yearly audits and action plans are required.	C
9.8	There are systems in place to ensure that all spaces are well maintained and support efficient patient flow to facilitate ergonomic and efficient working (includes decontamination)		B
9.9	There are systems in place to ensure that access to particular areas is restricted where appropriate (includes decontamination)	This should define the clinical environment from reception and decontamination facilities.	B
9.10	There are systems in place to ensure equipment is appropriate and available for all children and those with particular needs	E.g. hoists, bariatric beds.	B
9.11	There are systems in place to ensure the management and control of environmental conditions (includes decontamination)	E.g. temperature and ventilation control.	B
9.12	There are systems in place to ensure the maintenance and quality assurance of all equipment with corresponding records (includes decontamination)		B
9.13	The annual authorised engineer report for decontamination is actioned and approved by the organisation		B
9.14	There are systems in place to ensure that equipment replacement is planned (includes decontamination)		B

Standard 10: access and booking

The purpose of this standard is to ensure that the service is accessible, timely and patient centred.

No	Measure	Guidance	Level
10.1	The service has agreed standard operating procedures to support endoscopy waiting list management, booking and scheduling practices	The service has SOP's to support the waiting list team and includes booking and scheduling rules, access for new patients, pooling and escalation processes.	D
10.2	The service has defined, documented roles and responsibilities for endoscopy waiting list management, booking and scheduling management that meet the needs of the service	The roles and responsibilities should include who is responsible for day-to-day administration of waiting lists, scheduling and capacity management.	D
10.3	The service has a waiting list management system that records new and recall (planned/surveillance) patients	Services can answer 'yes' to this measure providing that a robust waiting list management system is used. An endoscopy service should be able to produce an up-to-date waiting list.	C
10.4	There is an agreed process for determining and monitoring the capacity of each endoscopy list	The capacity of each list must reflect the competence of each endoscopist, training lists will have reduced capacity.	C
10.5	The service has a process for identifying patients at risk of breaching waiting times and these are escalated and offered appropriate dates for admission		C
10.6	There is sufficient pooling of referrals to ensure that patients are booked in turn (unless there is a clinical reason why a patient should not be on a pooled list)	Robust processes exist in the service. For e.g. regular meetings between waiting list coordinator and operational management team that link into patient tracking lists.	C
10.7	There is a patient centred booking system that offers patients reasonable choice	Patient centred booking is at the heart of the patient experience and every child's family/carer or young person should be given an informed choice of when to attend. They may choose to agree on initial date given or defer. Booking opportunities should be equitable for all.	C
10.8	The service offers a partial booking system for planned/surveillance procedures	Another term used for planned or surveillance is planned repeat or any procedure that the referrer wishes to be done after a set period of time.	C

10.9	The service adheres to waiting times criteria for routine (<6 weeks for routine procedures) and urgent (<2 weeks for urgent procedures) waits		B
10.10	All appropriately vetted urgent inpatient procedures are performed within 48 hours	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 e.g. some colonoscopies.	A
10.11	There is an electronic scheduling system that facilitates efficient booking and scheduling as well as capacity planning		A

Standard 11: productivity and planning

The purpose of this standard is to ensure that resources and capacity are used effectively to provide a safe, efficient service. This is supported by sound business planning principles within the service.

No	Measure	Guidance	Level
11.1	There is a regular review of waits, demand, capacity and scheduling with key service leads	The service team needs to have access to accurate waits and capacity information to deliver and plan services effectively.	C
11.2	There is active backfilling of vacant lists, the frequency of unfilled lists is reviewed and there is sufficient flexibility in the job plans of endoscopists to enable backfilling of funded (i.e. staffed) capacity		C
11.3	The service offers an administrative pre-check for all patients before the date of the procedure to identify issues and to avoid late cancellations	An administrative pre-check is performed by booking/administrative staff to ensure that the service has the most up-to-date information about the patient's condition.	C
11.4	Booking efficiency is monitored (through DNA or WNB - was not brought and cancellation monitoring) regularly and is fed back to endoscopy staff		C
11.5	Room/ Theatre utilisation data (such as start and finish times and turnaround times) is collected, collated, reviewed and acted upon	The service should consider including as a minimum the following performance and productivity dataset: – overall/individual utilisation of lists – start and finish times audit – room turnaround audit – DNA and cancellation rates.	B
11.6	There is an annual planning and productivity report for the service with an action plan	Capacity planning is done annually and is supported by information based on previous years' trends and demand. A delivery plan is generated as part of the capacity plan.	B
11.7	Demand, capacity and utilisation data is used to inform short and long term business planning to ensure sufficient capacity, and the service has an agreed business plan if shortfalls are identified	See guidance for measure 11.6.	B

Standard 12: aftercare

The purpose of this standard is to ensure that the service implements and monitors systems to ensure that patients are prepared for discharge and understand what the plan of care is thereafter.

No	Measure	Guidance	Level
12.1	There is a general aftercare patient information sheet for all procedures performed in the service		D
12.2	There is a service contact number for patients, parent or legal guardian who have questions and experience problems	The important issue here for patients is to have a contact number and to be able to discuss problems with someone who knows about endoscopy including nursing staff.	D
12.3	There is a 24 hour contact number for patients, parent or legal guardian who have questions and experience problems and the contact is aware of guidelines to advise and manage patients		C
12.4	There is a process to provide a written explanation to patients, parent or legal guardian about their on-going care follow-up appointments		C
12.5	All patients, parent or legal guardian are told the outcome of the endoscopic procedure or next steps prior to discharge		B
12.6	All patients, parent or legal guardian are told if further information from pathological specimens will be available, from whom and when		B
12.7	All patients, parent or legal guardian are offered a copy of the endoscopy report or a patient-centred version of it. If this is deemed inappropriate, the reason is recorded in the file	This may include a copy of the discharge letter with endoscopy details and/or copies of clinic letter post endoscopy with results.	B
12.8	There are procedure specific aftercare patient information sheets for all procedures performed in the service		B

Standard 13: patient involvement

The purpose of this standard is to ensure that the service implements and manages systems to ensure that patients are able to feed back on their experience of the service and that the feedback is acted upon.

No	Measure	Guidance	Level
13.1	A complaints procedure is clearly available for patients, parents or legal guardian to access	If a complaint should occur complainants are provided with a named individual, a single point of contact with whom they can liaise. There should equality of access for all complainants, with particular consideration for those people who may find it more difficult to use the process. Patients and service users will have access to the Patients advice liaison service (PALS) and online access to the complaints process.	D
13.2	There are defined roles and responsibilities for obtaining and managing feedback from patients, parents or guardians		D
13.3	There are systems in place to ensure that patients and carers are able to give feedback in a variety of formats and in confidence	A variety of formats could be used such as verbal, written or online.	C
13.4	There are processes in place to ensure that complaints are reported, investigated, recorded and analysed with findings disseminated to relevant parties and acted upon	Patients or relatives who are unhappy with dealing with the ward or nursing staff directly should be signposted to the Patient Advice and Liaison Service (PALS) so that PALS can liaise with staff and managers. The Hospital has a responsibility to establish a complaint procedure in line with the statutory requirements and ensure this is accessible.	C
13.5	Patient feedback and agreed actions are disseminated and discussed	Information gained can be discussed at MDT, endoscopy service user meetings and other appropriate forums.	C
13.6	There are a number of processes to invite and learn from patient feedback consistently (e.g. focus groups, patient forums, questionnaires or invited comments)	A service should consider a number of approaches including questionnaires, social media or invited comments: it is up to the service to define what is best for their type of service.	C
13.7	The service conducts an annual patient feedback survey on the patients experience in endoscopy		C

13.8	An executive summary of patient feedback and actions is available and accessible within the department for patients to view	Each paediatric service will be responsible for displaying their own user service information in public areas/domain separate to adult departments.	B
13.9	Actions for annual patient feedback are reviewed within six months to ensure it has dealt with the problems identified	Patient feedback/information should be detailed into a report with actions. This system can be used to learn from patient's experiences to monitor and improve services. This information should be discussed at MDT and at the endoscopy service user meetings.	B
13.10	Details of changes made in response to patient feedback are reported to patients and carers who attend the service (e.g. 'you said, we did')	See 13.8.	B
13.11	Patients, parents or guardians participate in planning and evaluating services	There are a number of processes to invite and learn from patient feedback consistently (e.g. focus groups, patient forums, questionnaires or invited comments). Individual paediatric endoscopy teams will need to identify how this will be achieved.	A

Workforce domain

Standard 14: teamwork

The purpose of this standard is to ensure that the service implements and monitors systems for effective teamwork within the service.

No	Measure	Guidance	Level
14.1	The endoscopy team or division has a documented policy, outlining the ethos, culture, professionalism and discipline of how the team works together	The service has an agreed operational policy for the endoscopy service outlining the roles, responsibilities and ethos of the team.	D
14.2	The service has a documented matrix of staff competencies for all procedures undertaken. This should be clearly visible within the service, to ensure safe patient care	There should be clear documentation (e.g. as a list or matrix) of competencies and skills in endoscopy for both endoscopists and all supporting clinical staff who are involved in the endoscopy service. This should be readily accessible to all endoscopy staff.	D
14.3	There are systems in place to ensure that all staff are involved in the development of the service and the implications within their area of responsibility	The service has an endoscopy users group with representation from all the disciplines involved in delivering the service to discuss resources available and the utilisation of those resources to meet service need, best practice and quality.	C
14.4	The service has structured handovers for briefing and debriefing at each list to ensure safe efficient practices and learning	The team has a briefing session at the start and end of each list that allows open information exchange and feedback on patient throughput, team and equipment issues with a view to maintaining safety and quality. For supported documentation, see WHO Surgical Safety Checklist[3]	C
14.5	There are processes in place that actively encourage both core and wider team members to provide informal feedback about patient care, team functioning or the way the service is delivered, and to suggest ways these things could be improved	See 14.4.	C

14.6	There are systems in place to ensure that staffs are able to feed back in confidence on issues related to the service, including the team or team members	The team has an endoscopy users group with representation from all the disciplines involved in delivering the service to discuss resources available and the utilisation of those resources to meet service need, best practice and quality.	C
14.7	Time is allocated in job plans and the establishment to allow safety checks and equipment calibration to be performed	There are systems in place and key personnel identifiable to check equipment used for endoscopy is fit for purpose /maintained well and stored appropriately.	C
14.8	There is an annual review of the documented policy, outlining the ethos, culture, professionalism and discipline of how the team works together	The operational policy of the department has a review annually to ensure it still meets the ethos and working practice of the department. This should enable all members of the team to participate in feedback and provide service improvement ideas. This would normally be a specific SOP for paediatric endoscopy in joint centres with adult services.	B
14.9	There are processes in place for staff leaving or joining the clinical team part way through a procedure or activity, to ensure patient safety	As part of safety protocols all individuals that were not at team brief at the start of the endoscopy that join for procedures must identify themselves to the team at large before the procedure starts.	B
14.10	There are processes in place to review feedback and team surveys, and to create quality improvement plans	The service should have appropriate feedback surveys at least once a year that captures the views of children and their families that go through the service and the wider endoscopy team that support the service. The results of such surveys should be utilized to drive service improvements. Staff feedback survey to include all staff involved with paediatric endoscopy.	B
14.11	Quality improvement plans are reviewed 6 monthly to review progress and ensure that they are being acted upon		B
14.12	There are processes in place for recognising and rewarding the achievements of the team and individual members for outstanding performance	Plans for service improvements identified should be acted upon or a feasibility plan made within a suitable timeframe.	B

14.13	The team networks with other teams in other areas - both regionally and nationally - to share best practice and to help resolve service challenges	Good practice and achievement should be celebrated. The endoscopy service should take all available opportunities to nominate team members for local and national awards that recognise such achievements.	A
14.14	The endoscopy team hosts an annual away day to review team function, processes and opportunities for quality improvement	Networking is an important part of benchmarking against similar services to ensure best practice and standards are set and met.	A
14.15	The endoscopy team and users of the service are surveyed at least 1x/year about their perceptions on patient care, team leadership, team working and communication with patients and other professionals, and for ideas of how the service could be improved	The whole endoscopy service team including management and administration components have a strategy day away from the service to review service delivery and resources available.	A

Standard 15: workforce delivery

This standard ensures that the service has the appropriate workforce and that recruitment processes meet the needs of the service.

No	Measure	Guidance	Level
15.1	There are policies and systems in place to ensure that there are sufficient competent staff within the service with an appropriate mix of skills to enable delivery of the service	Key personnel numbers and competencies for a list to be undertaken are documented in operational policies and there are identified processes and procedures in place that address shortages. Planning of endoscopy sessions/lists is done and must take into account the availability of all the personnel needed to ensure safety.	D
15.2	The service rosters staff according to service activity and the competency level required to support it. Allocation of the workforce must be based on the expected duration of the service activity	See 15.1.	D
15.3	A workforce skill mix review is completed on at least an annual basis for all functions of the service and an impact assessment of the gaps is made and objectives are agreed on how these will be addressed in the immediate year		C
15.4	There are polices and systems in place to meet the induction requirements of the endoscopy team, including any additional service specific education and training	New staff and equipment are integrated into the service supported by relevant education and training. This may be theatre or endoscopy department wide, as long as paediatric endoscopy is specifically included.[4]	C
15.5	There is a training needs analysis for all new staff that supports the needs of the service	See 15.4.	C
15.6	There is a training needs analysis for substantive staff, which is agreed by the appropriate senior manager responsible for each workforce group	See 15.4.	C
15.7	The impact of recruitment processes for new or replacement senior or essential core staff do not adversely affect the running	Succession planning is key to ensure there is no break in service provision, safety or quality.	C

	of the service		
15.8	There are monitored processes to ensure the recruitment of suitable staff in a timely manner	See 15.7.	C
15.9	As a result of the workforce skill mix review an action plan is created and acted upon in a timely fashion	Where plans are agreed to recruit to enhance the skill mix of the team it is important this is done in a timely fashion so as not interfere with the smooth running of the service.	B
15.10	There is a training programme that meets the needs of new staff that is implemented in a timely and efficient way to minimise disruption to the service	Induction programmes for new staff should be structured and relevant to the role and be supported by the team at large to allow learning and skills progression. The programme should be responsive to the needs of the new starter, who should be able to feedback and agree set learning objectives.	B
15.11	The service specific induction programme for all new staff is modified on the basis of feedback	See 15.10.	B
15.12	Workforce development plans are in place in anticipation of future demands in the volume and type of future demand, for the next 2-5 years	Service development and contingency plans should be developed to ensure future resources and equipment needs of the service are looked at in a timely fashion to ensure continuity and avoid disruption to the service.	B
15.13	There is a process for the recruitment and induction of new staff, which allows a handover period prior to replacement	See 15.12.	A

Standard 16: professional development

The purpose of this standard is to assess the degree to which the service monitors and supports the development of the professionals working within it.

No	Measure	Guidance	Level
16.1	There are polices and systems in place to ensure that the workforce are properly trained and competent, including any additional service specific education and training	The training should cover medical, nursing and administrative workforces.	D
16.2	Where the wider team supports the patient, the training and competence of staff is equal to that of the core team	The wider team including paediatric ward staff, paediatric anaesthetists, paediatric day ward, theatre and recovery staff are appropriately trained for the tasks they undertake in providing and endoscopy service.	D
16.3	There is a nominated trainer supervising each team member until identified competencies have been achieved for them to undertake their role independently	The nominated trainer should have nationally agreed proficiencies e.g. mentor course/Training the Trainer (TTT). All staff should be appropriately supervised until they have achieved competency. There should be clear documentation of competency for the roles undertaken. This should follow nationally agreed training profiles.	C
16.4	There is an effective appraisal system in place for all professionals in the service that identifies learning needs, and changes in behaviour and practice required on the basis of performance metrics and other relevant information	To include all staff involved in providing the paediatric endoscopy service.	C
16.5	There is a system in place for providing all professionals in the service with individual performance data sufficient to reliably inform their appraisal and professional revalidation requirements		C
16.6	The appraisals identify what learning needs require interventions outside the organisation and how these will be resourced		C
16.7	There are systems and processes to allow staff to meet the requirements of professional revalidation		C

16.8	The professionals in the service have sufficient time and resource to meet their learning needs		C
16.9	There are processes to assess the competencies of non-substantive team members who support the team		B
16.10	There are processes for all staff to receive training and achieve competence when new or replacement equipment is introduced		B
16.11	There are processes for the responsibility and supervision of students, trainees and observers within the service	See 16.4.	B
16.12	Constant review of individual performance metrics identify areas for development in a timely way		B
16.13	There are robust processes to address performance issues so that patients and the viability of the service are not put at risk		B
16.14	There is a process to recognise or address concerns or performance issues		B
16.15	The service identifies ways of improving the efficiency of professional development such as joint learning events, helping professionals learn more efficiently and inviting external expertise to support in house training	This should be specifically for paediatric endoscopy.	A
16.16	The service provides professionally accredited endoscopy specific study days or courses	See 16.15.	A
16.17	There are educational facilitators attached to the team to support learning and development	See 16.15.	A

Training

Standard 17: environment, training opportunity and resources

The purpose of this standard is to ensure that trainees receive the optimal training environment that provides them with the correct orientation and training opportunities.

No	Measure	Guidance	Level
17.1	There is a trainee induction document	This document, which should be available in electronic format, needs to include: details of key endoscopy staff, appraisal, organisation of local training and training lead, link to JAG certification requirements, and other useful training information and simulation resources if available.	D
17.2	All local protocols and policies are available to the trainees	These should be available in electronic format and should be updated on a regular basis.	D
17.3	All trainees have access to the JETS e-portfolio, an endoscopic reporting system (ERS) capable of generating key audit data and image capture and/or video capability		D
17.4	There are some dedicated training and/or ad hoc training lists	The e-portfolio enables the local training lead to plan and monitor the training lists provided in the unit. On the training lead's summary screen there is a list of all lists performed by trainees using the e-portfolio.	D
17.5	There is a formal endoscopy induction programme for at least some of the new trainees	An induction programme adapted for local requirements is available.	D
17.6	There is a formal endoscopy induction programme for all new trainees to the service		C
17.7	There is a dedicated member of staff coordinating training lists		C
17.8	Feedback is obtained from all trainees on the availability of training opportunity and the quality of the training environment	The e-portfolio supports trainee feedback on the quality of the training received on any training list. This feedback is anonymous and can be viewed by the trainer via their portfolio.	C

17.9	There is a process in place that ensure that endoscopy trainees' exposure to emergency and urgent endoscopic procedures is maximised	Trainees are given opportunities to attend emergency and urgent endoscopy procedures.	B
17.10	There is a process for reviewing the delivery of endoscopy training, incorporating trainee feedback with a linked action plan and evidence of implementation of agreed actions	Feedback is actively sought from trainees on endoscopy training and is linked to an action plan as required	B
17.11	All endoscopy trainees have a dedicated appropriately supervised training list (at an annual rate of at least 20 lists per year) in addition to ad hoc training opportunities	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'.	B
17.12	There is a process in place for training lists to be identified and planned six weeks in advance		B
17.13	The content of the induction programme is reviewed each year and modified according to need		A
17.14	Processes are in place to ensure that actions taken in response to trainee feedback are effective		A
17.15	There is evidence of regular trainee representation at endoscopy users group meetings, and related governance, audit review / service evaluation or management meetings	Accelerated training programmes require local provision of an increased intensity of training lists. It is recognised that not all units are currently able to support this type of training.	A

Standard 18: trainer allocation and skills

The purpose of this standard is to ensure that trainees working within an endoscopy service have nominated trainers who demonstrate both acceptable performance in their clinical roles and who have received appropriate training as trainers. Its purpose is also for trainers to remain up to date in training techniques, have assessments of their performance and respond to trainee feedback.

No	Measure	Guidance	Level
18.1	There is a nominated trainer for each endoscopy trainee		D
18.2	All endoscopy trainers are registered on JETS		D
18.3	There is a nominated local training lead with overall responsibility for ensuring the induction and appraisal of trainees (with recognised sessional time in their job plan to support this role)	The local endoscopy lead has recognised sessional time in their job plan	D
18.4	Local training lead has attended a JAG approved Training the Trainer course and has maintained and updated trainer skills relevant to the procedures for which they act as a trainer within the revalidation cycle	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).	D
18.5	Trainees regularly provide feedback to endoscopy trainers via JETS (as an agreed action of participation in training lists)	The e-portfolio has a trainer login which allows the trainer to review their trainee's performance and review their own training experience (e.g. number of dedicated training list, anonymous feedback etc.). The training lead can use this feedback to support appraisal of training.	C
18.6	The performance of all endoscopy trainers is regularly reviewed and meets the standards of the BSPGHAN quality and safety indicators	This standard relates to the endoscopic skills (audited KPIs) for all trainers (i.e. providing training on dedicated or ad hoc lists).	C

18.7	All trainers supervising dedicated training lists have attended (or are supported to attend) a JAG approved Training the Trainer course and have maintained and updated trainer skills relevant to the procedures for which they act as a trainer within the revalidation cycle	This standard supports the principle that all trainers should maintain and develop their training skills. Completion of one or more of the following can be used as evidence of having met this measure: 1. By review with the local training lead of their trainee feedback showing acceptable performance. 2. By providing evidence of participation in and JETS feedback from Faculty involvement on a JAG approved Endoscopy training course. 3. If a TTT/TET/TCT/TGT style course has been performed within the revalidation cycle. 4. If there is evidence of a formal Medical Education qualification - e.g. PCME, Diploma or MSc level course. 5. Deanery related trainer skills course that may be transferable to Endoscopy practice (and which has been validated for CPD points).	B
18.8	All trainers undergo an evaluation of their key performance indicators and training expertise at least 1x/year (based on KPIs, JETS data and annual unit training survey)	It is recommended that this standard is incorporated into an annual appraisal.	B
18.9	There are recommendations for trainer development in response to evaluations of their training expertise (based on KPIs, JETS data and annual unit training survey)	See18.8.	B
18.10	There is an annual direct observation of training skills assessment for all endoscopy trainers (based on DOTS and LETS assessment tools)	DOTS and LETS tools are available via the JETS e-portfolio.	A
18.11	There is a process in place for ensuring that the actions taken following review of trainer evaluations are acted upon and effective		A

18.12	At least one trainer from the unit participates as training faculty on a JAG approved training course at an approved JAG Training Centre each year	Local Training Leads should provide recommendations to JAG Regional Training Centre Leads to support of the development of individual trainers and augment regional training faculty.	A

Standard 19: assessment and appraisal

The purpose of this standard is to ensure that trainees have access to all tools required to make an assessment of their performance, are released for training linked to learning needs and are supported in providing evidence for certification of competence. The standard ensures regular appraisal of trainees' progress against training goals and assessment, and monitoring of their independent practice.

No	Measure	Guidance	Level
19.1	All endoscopy trainees are registered on JETS e-portfolio and linked to the current training unit as part of induction into the endoscopy unit		D
19.2	All endoscopy trainees who have not completed mandatory JAG Basic Skills courses have booked a date for an appropriate course	Guidance is available in the JETS user guide.	D
19.3	All endoscopy trainee activity is recorded on JETS	See 19.2.	D
19.4	There is a formal baseline appraisal completed in the JETS e-portfolio for all trainees to identify their training needs	See 19.2.	C
19.5	There is a formal assessment of endoscopic skills conducted by the local training lead (or nominated deputy) for all trainees seeking to perform independent procedures	The e-portfolio uses JAG-approved Direct Observation of Procedure or Skills (DOPS) as the main tool of trainee assessment. These can be filled in during any training list. Learning objectives can be set during completion of the DOPS forms-these then populate the trainees's personal development plan.	C
19.6	Trainees are assessed regularly using DOPS on JETS (in accordance with JAG certification requirements for the procedure for which they are training)	Trainees require a minimum of 10 DOPS forms for basic Upper GI or Lower GI certification. It is recognised that there may be an increased need for DOPS at both the start of training and as a trainee approaches summative sign off.	C
19.7	There is an agreement within the department by endoscopy trainers for defining and monitoring independent practice of trainees		C

19.8	The key performance indicators of trainees practicing independently are regularly monitored and reviewed by the Local Training Lead with evidence of action according to local Clinical Governance policy if KPIs are below acceptable standards	The JETS/KAIZEN e-portfolio documents progression of training. This record is transferable from hospital to hospital. It is helpful to all trainers involved in the training process for documentation of appraisal meetings to be complete. This allows for review of the training goals that have been set and progress made against these targets. This is important for continuity of training and maintenance of training standards.	C
19.9	If an endoscopy trainee who is not on the independent register performs a procedure unsupervised an adverse event is registered		B
19.10	All endoscopy trainees have an appraisal with their trainer completed in their JETS e-portfolio at baseline and at the end of their attachment	Guidance on completing appraisal using JETS is available in the JETS user guide.	B
19.11	The local training lead ensures that local arrangements for summative DOPS required for the JAG certification support the sign off process		B
19.12	The local training lead regularly reviews the number and quality of DOPS assessments performed by trainers to ensure supportive training	It is recommended that this is included in the annual appraisal process.	B
19.13	In addition to baseline and end of attachment appraisal in the JETS e-portfolio there is evidence of intermediate appraisal at least every 6 months (appropriate to the duration of a trainee's attachment) with adjustment of training goals		A
19.14	There is evidence of training lists being actively modified and action plans documented on DOPS assessments in response to the training needs defined and documented in the JETS e-portfolio appraisal forms		A

Terms and definitions

For the purposes of this document, the following terms and definitions apply.

Accreditation	The evaluation of an organisation's systems, processes or product that investigates whether defined standards and minimum requirements are satisfied
Audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change; clinical audits are central to effective clinical governance as a measure of clinical effectiveness
BSG	British Society of Gastroenterology
Clinical governance	A system through which healthcare providers and partners are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish
Clinical service leader	A named individual of a clinical service leadership team with responsibility for leading the clinical service
Clinical service strategy	An overarching approach of a clinical service that encompasses all plans, procedures and policies
Competence	Having the expertise, knowledge and/or skills, and in a clinical role the clinical and technical knowledge, required to carry out the role
DNA	Did not attend

Endoscopy service	A dedicated area where medical procedures are performed with endoscopes, which are cameras used to visualise structures within the body, such as the digestive tract and genitourinary system; endoscopy services may be located within a hospital, incorporated within other care centres, or may be stand-alone.
JAG	The Joint Advisory Group on GI Endoscopy
KPI	Key performance indicator
Lead clinician	A named clinical staff member for a clinical specialty with a remit for leading the clinical staff within a clinical service *Note*: The lead clinician might have a non-medical role, e.g. a nurse or other registered professional
Leadership team	Clinical and managerial staff members with responsibility for leading a clinical service
Organisation	A legal, regulated body and location where clinical care is governed and provided or coordinated
Patient centred	Providing *care* and support that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that *patient* values guide all clinical and support decisions
Policy	A document that states, in writing, a course or principles of action adopted by a provider and/or clinical service
Procedure	A specified way to carry out an activity or a process (ISO 14971:2007, 2.12)

Quality	Quality is used in this document to denote a degree of excellence
Quality improvement plan	A document, or several documents, that together specify quality requirements, practices, resources, specifications, measurable objectives, timescales and the sequence of activities that are relevant to a particular clinical service or project to achieve the objectives within the timescales given
Risk assessment	A process used to determine risk management priorities for clinical service delivery, user treatment and/or care by evaluating and comparing the level of risk against healthcare provider standards, predetermined target risk levels or other criteria
Roster	A list or plan showing turns of duty or leave for individuals or groups in an organisation, clinical service or pathway
Skill mix	A combination of different types of staff members who are employed in a clinical service who have the required skills and competencies to carry out the work of the clinical service and deliver the pathway
Staff (workforce)	A person (clinically or non-clinically trained) working in the endoscopy service including those who are: employed, clinical eg nurses, doctors, healthcare assistants and technicians other non-clinical eg administrative staff agency/bank/voluntary
Service user	A person who receives treatment and/or care from the endoscopy service and the defined population for whom that endoscopy service takes responsibility: examples of endoscopy service users are patients, carers and advocates
Trainee	A trainee is an individual taking part in a trainee programme (e.g. medical or nursing) or who is an official employee of endoscopy service that is being trained to the job he/she was originally hired for: literally an employee in training

References

[1]http://www.gmc-uk.org/static/documents/content/Consent_-_English_0617.pdf (Paragraphs 54-56)

[2]http://www.gmc-uk.org/static/documents/content/0_18_years.pdf.

[3]www.nrls.npsa.nhs.uk/resources/?entryid45=59860

[4]http://rcnhca.org.uk/

JAG Paediatric Global Rating Scale (P-GRS): version for paediatric services in UK

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