GUIDELINES FOR THE TRAINING, APPRAISAL AND ASSESSMENT OF TRAINEES IN GASTROINTESTINAL ENDOSCOPY

and for the ASSESSMENT OF UNITS FOR REGISTRATION AND RE-REGISTRATION

Joint Advisory Group on Gastrointestinal Endoscopy

(Representing the Royal Colleges of Physicians of the UK, The Royal Colleges of Surgeons of the UK, The Royal College of Radiologists and The Royal College of General Practitioners)

2004

This document is effective until 1st March 2006
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FOREWORD BY THE CHAIRMAN

This is the third JAG document to be published since 1999.

Endoscopy training has been the subject of much attention, by JAG, SAC (Gastroenterology), the BSG and other bodies more concerned with service provision. These include the National Patient Access Team, the NHS Modernisation Agency and the National Cancer Plan Team.

Developments to continue the improvements in training in endoscopy have been in several areas. These include:

(a) individual assessment of trainees competence
(b) development of JAG initiated (now called JAG compliant) training courses
(c) approval of training centres to deliver JAG compliant courses
(d) planning for the re-registration and accreditation of training units and
(e) new endoscopy training initiative by National Cancer Plan.

In this document the background and the proposals for each of the above are laid down with the appropriate documentation.

The JAG is aware that there is a growing impetus in the endoscopic community to improve standards and availability of endoscopy and that frequently individuals and units suffer from frustration when improvements are slow to develop. It must be remembered however that direct funding for the generality of endoscopic services is not available, nor has there been a unified representative body to oversee such training developments until the establishment of JAG.

We believe that endoscopy is now seen as an important discipline that may well hold the key to future Government health objectives (such as Colon Cancer Screening), and is thus now entering the political consciousness. My thanks, as ever, are to the members of the committee who are listed on the next page and in particular to Nicholas Grant and Sarah Carruthers who provide the support and much of the work of the committee.

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Chairman JAG

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February 2004
### MEMBERSHIP OF THE JAG

**Current members**

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<tr>
<td>Chairman</td>
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<td>JCHMT</td>
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**Co-opted:**

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<td>NHS Modernisation Agency</td>
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<td>Chair, BSG Training Committee</td>
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<tr>
<td>Endoscopy Tutor, Raven Dept of Education, RCS England</td>
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**Previous representatives [since 2001]**

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<td>JCHST: Professor M Griffin, Mr R J Leicester</td>
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<td>RCR: Dr D F Martin</td>
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<td>BSG: Dr I Barrison, Professor R Bramble, Dr P Fairclough, Dr M Wilkinson</td>
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<td>TIGS: Dr A Fraser, Dr J Jones, Dr K Ragunath</td>
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<td>AUGIS: Mr W H Allum</td>
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### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ACP</td>
<td>Association of Coloproctology of Great Britain and Ireland</td>
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<tr>
<td>ATLS</td>
<td>Advanced Trauma Life Support</td>
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<tr>
<td>AUGIS</td>
<td>Association of Upper Gastrointestinal Surgeons</td>
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<tr>
<td>BSG</td>
<td>British Society of Gastroenterology</td>
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<td>CCST</td>
<td>Certificate of Completion of Specialist Training</td>
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<tr>
<td>CoD</td>
<td>Council of Deans and Heads of UK University Faculties for Nursing, Midwifery and Health Visiting</td>
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<tr>
<td>EUS</td>
<td>Endoscopic Ultrasound</td>
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<tr>
<td>IRMER</td>
<td>The Ionising Radiation (Medical Exposure) Regulations 2000, (IR(ME)R 2000)</td>
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<td>JAG</td>
<td>Joint Advisory Group on Gastrointestinal Endoscopy</td>
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<tr>
<td>NMC</td>
<td>Nursing &amp; Midwifery Council</td>
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<td>PEG</td>
<td>Percutaneous Endoscopic Gastrostomy</td>
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<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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<td>RCN</td>
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<td>RCPCH</td>
<td>Royal College of Paediatrics &amp; Child Health</td>
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<td>RCR</td>
<td>Royal College of Radiologists</td>
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<tr>
<td>RITA</td>
<td>Record of In Training Assessment</td>
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<td>SAC</td>
<td>Specialist Advisory Committee (of JCHMT or JCHST)</td>
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<td>SpR</td>
<td>Specialist Registrar</td>
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<td>TIGS</td>
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<td>UKCC</td>
<td>United Kingdom Central Council for Nursing, Midwifery and Health Visiting</td>
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GENERAL RECOMMENDATIONS ON TRAINING IN GASTROINTESTINAL ENDOSCOPY

FACILITIES

1. The training unit should be furnished with modern endoscopy equipment. Fluoroscopy, not necessarily in the Endoscopy Unit, should be available for selected cases. High quality video-endoscopic equipment is essential, with televsual display and image recording facilities.

2. Training units should be staffed with adequate numbers of Endoscopy Assistants and clerical and secretarial personnel along the lines laid down by the BSG.

3. Cleaning of equipment must be undertaken as laid down by the BSG and all trainees should have practical experience of cleaning scopes.

4. Facilities for sedation, monitoring, resuscitation and recovery must be provided as recommended by the BSG.

5. Where fluoroscopy is used, all trainees should have knowledge and understanding of the legal requirements placed upon them as referrer, practitioner and operator under the IRMER (May 2000).

ENDOSCOPIC EXPERIENCE

Training

1. Any practitioner who is to undertake gastrointestinal endoscopy should receive formal training in the principles and practice of safe endoscopy. Training should include the indications for, as well as the contraindications to each type of endoscopic procedure.

2. In order to maintain competence, it is not recommended that training should be provided for practitioners who are not going to have a regular sessional commitment to endoscopy.

3. Training in endoscopy should only take place in units that have been approved by the JAG.

4. Endoscopy training should be provided as part of a multi-disciplinary gastroenterology service with co-operation between physician, surgeon, radiologist and pathologist. Joint ward rounds and meetings involving histology, radiology and surgery are desirable to achieve high standards of patient care. General practitioners, nurses and other non-medical endoscopists who undertake training in gastrointestinal endoscopy must do so in units approved by the JAG and must register with the JAG.

5. Training consists of in-service training and attendance at JAG initiated courses or equivalent JAG approved courses (now called JAG compliant courses).

6. The requirements for competence in each endoscopic modality may be revised from time to time. Trained practitioners in gastrointestinal endoscopy are expected to maintain their knowledge and skills through a commitment to continuing medical education and professional development.

7. Training should include formal instruction in the technique of conscious sedation as well as the management of sedation related complications and their avoidance.

8. Trainees should have training in the causes, recognition and management of endoscopy related complications as well as instruction in how these complications can be avoided.

9. All forms of therapeutic endoscopy should be taught only after adequate skills for diagnostic procedures have been acquired. Procedures should be carried out initially only under supervision and subsequently independently as competence is achieved.
10. Trainees should be able to undertake obtaining informed consent from patients with a wide range of educational achievement and from a variety of ethnic and racial backgrounds.

11. Trainees should be able to communicate their endoscopic findings and the implication of the findings to the patient, their relatives and carers. They must be able to provide a high standard of written reporting for records and communication to other doctors.

12. Trainees should have specific training in the ‘giving of bad news’ and in the handling of any endoscopic complications.

13. Trainees should have knowledge of and understand the background to current surveillance protocols for gastrointestinal diseases.

Assessment and appraisal

14. Trainees are required to maintain an accurate logbook of their experience, using the content and layout recommended and supplied by the appropriate SAC or College. These should be supplemented by an audit of the trainee’s endoscopic work, usually generated from the endoscopy unit reporting system. A written record of the number and variety of procedures carried out under supervision and independently should be kept for inspection. Use of the assessment forms included in this document, or similar forms, is recommended.

15. The use of a portfolio of assessed cases should be used instead of a simple logbook.

16. Trainers should have attended a ‘Training the Trainers’ course specific to Endoscopic skills training when these are available and use a standardised formal assessment of endoscopic skills as suggested on pages 36-37.

Educational supervision

17. Trainers are required to provide appraisal during training, and assessments that contribute to the evidence of competence of the trainee. Use of specific assessment forms (pages 36-37) is recommended to provide a portfolio of assessed cases.

18. Trainers must provide adequate on-site supervision for trainees at all times, as defined in the curriculum. This may require additional resources.

19. Satisfactory assessments from trainers, and completed log books which demonstrate that the trainee meets the criteria of competence are required for a trainee to be assessed as competent in a particular procedure.

COURSES

1. All trainees must attend a Basic Skills (Foundation course) in Endoscopy, initiated by or compliant with JAG standards (JAG compliant course). Courses should include such topics as patient care, maintenance, cleaning and disinfection of endoscopes and equipment, electrical hazards and the recognition and management of the complications of endoscopy. The principles and safe practice of conscious sedation should be formally covered. The general administration of an endoscopy unit should also be covered, together with information on the Modernisation Agency Endoscopy Project.

2. For those trainees undertaking therapeutic procedures, attendance at an approved advanced therapeutic endoscopy course is essential.

3. Courses on therapeutic endoscopy should include stricture dilatation, PEG and prosthetic tube placement, polypectomy, treatment of GI bleeding and palliative techniques. The content of these courses will change as technology evolves.

4. It is understood that facilities for training or courses will be more widely available during the lifespan of this document.
TRAINING IN OESOPHAGO-GASTRO-DUODENOSCOPY (OGD)

FACILITIES

1. Training should be in a unit carrying out a minimum of 1,000 OGD examinations per year so that a full range of conditions is observed and diagnostic and therapeutic measures encountered.

2. Trainees will be expected to enhance their experience in units performing more than twice this number of procedures.

ENDOSCOPIC EXPERIENCE

Diagnostic

1. Trainee endoscopists should attend regular weekly (or more frequent) sessions for at least six months.

2. Trainees should carry out at least 200 diagnostic examinations, within the course of a year, under supervision and then undertake further examinations, when judged competent, with a degree of independence in selected cases, to a total minimum of 300 examinations to ensure adequate exposure to a full range of clinical material. The number of trainees working in a unit must therefore be commensurate with the available clinical workload.

3. Trainees should be able to intubate patients whether they are sedated or not, with a high success rate and with minimal trauma and discomfort.

4. Passage of the endoscope through the pylorus should be achieved in the majority of patients unless there is evidence of significant pyloric obstruction.

5. Familiarity with endoscopic blind areas and the techniques to enable visualisation of these areas is vital.

6. Trainees should be able to take biopsies from all areas within the reach of the endoscope and provide adequate tissue for histological or other processing.

Therapeutic

7. Trainees embarking on a programme of training may only carry out therapeutic procedures after competence has been obtained in diagnostic procedures. Such therapeutic endoscopies must be carried out in an appropriate clinical setting.

8. Trainees should be able to treat bleeding ulcers, vascular lesions and oesophageal varices. They should have knowledge of risk assessment in bleeding patients and detailed knowledge and understanding of the indications and contra-indications for endoscopic therapy as well as understanding the complications of endoscopic therapy. Trainees should be able to inject bleeding lesions, band varices and preferably have some experience in the use of thermal methods to stop bleeding.

9. Trainees should be able to treat benign oesophageal strictures by oesophageal dilatation. They should have knowledge and understanding of the indications for, contra-indications to and complications of endoscopic therapy. Recognition and management of complications of endoscopic dilatation must be fully understood. Trainees should be familiar with both over the wire methods of dilatation and through the scope balloon dilatation. Familiarity with the methods used to treat achalasia is essential.

10. The use of fluoroscopy in the placement of stents and for dilatation of strictures should be understood as well as legal and safety issues (IRMER).

11. Trainees should understand the principles behind, and indications for, the removal of ingested foreign objects and be able to undertake such procedures.
12. Trainees should understand the indications for PEG tube insertion together with knowledge of the ethical issues and contraindications for PEG tube insertion. They should be able to undertake both the endoscopic and surgical parts of the insertion procedure and manage complications.

13. Trainees should have knowledge and understanding of the methods available for the palliation of oesophago-gastric malignancy. Experience of dilatation, thermal ablative techniques and stent placement should be acquired. Management of complications arising from endoscopic therapy and salvage techniques must be understood.

14. Trainees should be able to undertake polypectomy safely and have knowledge of the techniques of dye spraying and endoscopic mucosal resection.

COURSES

1. Trainees should attend a Basic Skills (Foundation course) in endoscopy initiated by or compliant with JAG standards (JAG compliant course).

2. Trainees undertaking therapeutic endoscopy should attend an advanced Therapeutic Upper Endoscopy course initiated by or compliant with JAG standards (JAG compliant course).
TRAINING IN COLONOSCOPY

As with OGD, in-service training is most important.

FACILITIES

1. The training unit should undertake at least 400 procedures a year.

2. Rotations should enable trainees to enhance their experience in units performing more than twice this number of procedures.

ENDOSCOPIC EXPERIENCE

Diagnostic

1. Most trainees in colonoscopy should have acquired basic endoscopic skills, usually by prior training in upper GI Endoscopy or Flexible Sigmoidoscopy. For trainees in Coloproctology, attendance at a JAG compliant Basic Skills Foundation or Flexible Sigmoidoscopy course to learn the background to safe endoscopy would be an alternative starting point.

2. Trainees should understand appropriate techniques of patient preparation, the mechanics of the procedure and its indications, limitations and the complications.

3. Each trainee should be able to perform at least 100 procedures within the course of a year and will be considered to have achieved a satisfactory level of competence when able to reach the caecum where indicated. It is expected that the caecal intubation rate should exceed 90% in those patients without stricturing or marked faecal contamination.

4. Trainees should also be able to demonstrate that they can intubate the ileum in at least 50% of procedures where indicated. Current data suggest that many trainees will need to perform more than 200 examinations to meet this criterion.

Therapeutic

5. Trainees should be competent in the techniques of hot biopsy, polypectomy, and treatment of colonic bleeding.

6. Trainees should be familiar with balloon dilatation of strictures and techniques to stop bleeding and treat angiodysplastic lesions.

7. Some trainees may wish to gain a higher degree of training in the more advanced techniques of dye spraying, tattooing, endoscopic mucosal resection and tumour debulking and stenting.

COURSES

1. Trainees should attend a Basic Skills in Colonoscopy course initiated by or compliant with JAG standards (JAG compliant course).

2. Trainees wishing to undertake more advanced techniques should attend an advanced colonoscopy course approved by JAG.
TRAINING IN FLEXIBLE SIGMOIDOSCOPY

FACILITIES

1. Training should only take place in a JAG recognised training unit during sessions primarily for the examination of the lower bowel.

2. The trainer should be an experienced endoscopist involved in regular flexible sigmoidoscopy or colonoscopy sessions.

3. Training units should undertake a minimum of 200 procedures per year.

ENDOSCOPIC EXPERIENCE

Diagnostic

1. Intended trainees in Flexible Sigmoidoscopy should first acquire basic knowledge of the principles and practice of endoscopy.

2. Trainees should understand appropriate techniques of patient preparation, the mechanics of the procedure and its indications, limitations and complications.

3. Each trainee should be able to perform at least 100 procedures within the course of a year and will be considered to have achieved a satisfactory level of competence when able to reach the descending colon where indicated. It is expected that the descending colon intubation rate should exceed 90% in those patients without stricturing or marked faecal contamination.

4. On the best evidence to date, trainees should perform at least 50 examinations under direct supervision and at least a further 50 examinations with immediate advice available.

5. Trainees should become competent in taking diagnostic biopsies.

6. Competence in Flexible Sigmoidoscopy does not equate with competence in colonoscopy.

Therapeutic

7. Trainees undertaking techniques of polypectomy must undergo adequate training, including knowledge of the principles of safe diathermy technique.

COURSES

1. Trainees should attend a Basic Skills (Foundation course) in endoscopy and a Flexible Sigmoidoscopy course initiated by or compliant with JAG standards (JAG compliant courses).
TRAINING IN ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP)

FACILITIES

1. High quality video-endoscopic equipment is essential and should be used in close conjunction with high quality image-intensification X-ray equipment. The latter should preferably be digital and have the ability to display previous images alongside current screening images.

2. Training centres should be able to demonstrate that they have sufficient throughput of cases to provide meaningful audit of their success and complication rates. Training centres should have sufficient workload to allow trainers to maintain and improve their skills and to allow trainees sufficient access to new cases. It may be appropriate for neighbouring hospitals to collaborate in order to provide an ERCP training facility of a sufficient size to be viable for training [the recommended number of procedures is 250 per year]. For units not achieving 250 procedures per year, the JAG will be prepared to consider special requests for registration based on firm evidence that trainees are undertaking at least the recommended number of procedures [see paragraph 2 below].

3. Frequent multi-disciplinary meetings should be held to discuss cases.

4. As the technique is radiological as well as endoscopic, it is essential to have the support of a consultant radiologist with an interest in ERCP and a subspecialty GI interest.

5. Where ERCP is performed in a Radiology department not directly linked to an Endoscopy unit, facilities for sedation, monitoring, resuscitation and recovery should at least match those required in the Endoscopy unit.

ENDOSCOPIC EXPERIENCE

1. Trainees should ideally be competent under supervision in diagnostic endoscopy and have had relevant training in the use of diathermy before starting ERCP.

2. Although trainees must aspire to internationally acceptable standards for cannulation success - a 90% selective success rate for uncomplicated cases has been proposed - it is unreasonable to demand this level of performance from trainees by the end of their SpR training. This is partly because MRCP and EUS have largely obviated the need for diagnostic ERCP; straightforward cases are now relatively unusual in most units. The majority of ERCPs are currently therapeutic procedures which may be more difficult to complete. Clinical imperatives tend to result in trainers taking over at a relatively early stage since therapeutic success is essential. It is also difficult to define the success rates of therapeutic procedures done by trainees for the same reasons; frequently both trainee and trainer do a therapeutic ERCP. Defining a specific number of unassisted diagnostic and therapeutic ERCPs is not the preferred option. Pending the introduction of formal validated assessment methods at the time of CCST, the SpR who is intending to practice ERCP must in the opinion of their trainer, be:

   - aware of the indications, limitations and complications of diagnostic and therapeutic ERCP
   - able to identify the papilla in>95% of patients who have not undergone gastric surgery.
   - competent in those manoeuvres which facilitate cannulation of the biliary tree and the pancreatic duct
   - able independently to perform sphincterotomy, stone extraction and stenting and display a safe and potentially successful approach to these technical skills.

3. Trainees should be able to interpret the radiological findings and assess the significance of these in the context of the patient's illness. They should be able to act appropriately and immediately on their findings.

4. Trainees should have knowledge of the treatment of post sphincterotomy bleeding as well as the management of other procedure related complications.
5. Trainees should be able to assess the need for, and be able to undertake tissue sampling (biopsy and brush cytology) in the biliary tract and pancreas.

6. Trainees should have experience of mechanical lithotripsy for common bile duct stones.

7. Trainees should have an understanding of radiological techniques, both non-invasive and invasive, which can complement an ERCP Service. This should include spiral CT, percutaneous cholangiography and drainage, MRCP and Endoscopic Ultrasound.

8. Trainees should have an understanding of radiological techniques, both non-invasive and invasive, which can complement an ERCP Service. This should include spiral CT, percutaneous cholangiography and drainage, MRCP and Endoscopic Ultrasound.

9. Trainees should develop knowledge of the availability of complex endoscopic, radiological and surgical treatment options and the need for appropriate referral as adjuncts to or instead of ERCP in the management of complex conditions.

10. Each training unit (or unit combination) should have up-to-date audited figures to indicate success, complication and mortality rates of ERCP. These rates should be comparable statistically with available published data.

11. JAG acknowledges that further post CCST training may be necessary to permit independent single-handed practice in some of the therapeutic techniques.

COURSES

1. Trainees should attend a Basic Skills (Foundation course) in endoscopy and also the Therapeutic Upper Endoscopy course initiated by or compliant with JAG standards (JAG compliant courses).

2. Trainees wishing to undertake a sessional commitment to ERCP should attend an ERCP course initiated by or compliant with JAG standards (JAG compliant course).
RECOMMENDATIONS FOR TRAINING IN SMALL BOWEL ENTEROSCOPY

FACILITIES

1. Training should be carried out in a unit performing regular small bowel enteroscopies, ideally 50 or more per year.

2. The training unit should be equipped with modern, preferably video, small bowel enteroscope/s, preferably of the push type.

3. Facilities for treatment of vascular lesions of the small bowel must be available, as well as biopsy forceps.

4. Suitable overtubes to prevent looping in the stomach should be available.

ENDOSCOPIC EXPERIENCE

1. Trainee endoscopists should have completed training in both diagnostic and therapeutic upper gastrointestinal endoscopy.

2. Trainees should attend regular sessions of small bowel enteroscopy and should carry out the procedure under supervision until adequate experience has been obtained to permit independent practice.

3. Trainees should be formally trained in the indications for, contra-indications to, and complications of the procedure.

4. Trainees should be able to treat bleeding lesions and tattoo areas of concern (see paragraph 8 of OGD training on page 6).

5. Trainees should have experience of undertaking polypectomy safely before they undertake small bowel enteroscopy.

6. Trainees should have seen and assisted at on-table enteroscopy within the setting of either a laparotomy or laparoscopy.

COURSES

1. Trainees should have attended both the Basic Skills (Foundation course) in endoscopy and advanced Therapeutic Upper Endoscopy courses initiated by or compliant with JAG standards (JAG compliant courses).
RECOMMENDATIONS FOR TRAINING IN ENDOSCOPIC ULTRASOUND

FACILITIES

1. Training should be in a unit undertaking regular EUS examinations of at least 200 procedures per year.

2. Training should occur in units performing a wide range of diagnostic and therapeutic procedures because EUS is complementary to such procedures (ERCP, Laser and Stenting).

3. The training unit should be furnished with modern EUS equipment including image-recording devices.

4. Training will probably initially be undertaken using cross-sectional radial scanning scopes to gain experience in the anatomy of the upper GI tract. The use of linear array EUS scopes with real time guided biopsy is likely to develop rapidly, and ideally, trainees should see such techniques being used.

5. Training units should have at least one skilled EUS trainer recognised by their peers as experienced and having a dedicated commitment to EUS.

6. Training units should offer experience in the established indications for EUS e.g. oesophagogastric cancer, large gastric folds, intramural lesions and cancers of the pancreas, rectum and lung. In addition, its use in assessing the biliary tract in cases of cholelithiasis and the assessment of pancreatic ductal and cystic lesions is important.

7. The use of EUS in the assessment and biopsy of mediastinal masses should be understood.

ENDOSCOPIC EXPERIENCE

1. Trainees should attend regular weekly sessions for at least six months.

2. Trainees should be competent in diagnostic and appropriate aspects of therapeutic upper gastrointestinal endoscopy before learning EUS. ERCP experience although not essential, is recommended for those with an interest in pancreatico-biliary EUS.

3. While radial and curved linear array instruments are equally valid for EUS, imaging is probably easier with radial systems and these should be used first to develop EUS skills.

4. Interventional techniques should only be learnt after trainees have become competent in diagnostic imaging.

5. Trainees should receive their training in a multidisciplinary environment so as to fully understand the role of EUS and the context of the EUS findings, particularly in the staging process of gastrointestinal cancer.

6. Training should include the formal study of anatomy atlases, atlases of EUS appearances and other audiovisual aids.

7. It is recommended that a period of intensive observation or training in a centre of excellence performing large numbers of EUS procedures in the UK or overseas should be considered as a means of accelerating the learning process.
COURSES

1. Trainees should attend the meetings of the EUS Users Group of the UK.

2. Attendance at International EUS meetings is recommended.

3. Trainees should attend an EUS training course initiated by or compliant with JAG standards (JAG compliant course), when they are available.
The JAG recognises that many hospitals now employ nurses to undertake diagnostic and in some cases therapeutic GI endoscopy. The UKCC (now NMC) document “The Scope of Professional Practice” supports nurses developing their professional practice, as long as the “nurse concerned is competent for the purpose, and mindful of the personal professional accountability they bear for their actions” In addition other professionals (e.g radiographers) and other non-medical practitioners are now being trained in endoscopy.

Regardless of professional background, all non-medical endoscopists should have been trained to the standards expected of a medical endoscopist and their training requirements should be addressed in a similar manner to those of nurses.

GENERAL RECOMMENDATIONS

1. It is the responsibility of nurses and other non-medical endoscopists to ensure they are fit to practise and of doctors to ensure that responsibility is passed to a person fit to practise.

2. Nurse and other non-medical endoscopists are accountable for their actions and omissions regarding the patient during an episode of endoscopy. Doctors do not accept responsibility for their actions, only their own delegation.

3. A situation such as endoscopy involves the use of special skill and each practitioner will be judged against the standard of an ‘ordinary skilled practitioner’, professing to have that special skill.

ENDOSCOPY EXPERIENCE

1. Trainee endoscopists, whatever their background, should ensure their endoscopy training is the same as that for any endoscopist.

2. The law does not recognise the term “Nurse Endoscopist” or any other such title, only nurses, radiographers or others undertaking endoscopy as part of their role. Therefore any nurse undertaking any GI endoscopy, regardless of title, (e.g. Stoma Care Nurse, Colorectal Practitioner, Nurse Endoscopist), role or previous experience should be trained to the standards contained within this document.

3. Trainees’ education should be at a level and depth required to support clinical work and patient management.

4. Trainees should understand it is their responsibility to ensure their training and practice is contemporary, evidence based and undertaken within national guidelines, including this document.

5. Mechanisms should be developed to ensure on-going assessment, updating and audit of practice.

6. The use of a professional portfolio to include a logbook is required to confirm learning needs and evidence of adequate training.
COURSES

1. Courses undertaken, including formal university linked nurse endoscopy training courses should be accredited by the JAG (JAG approved). Attendance at the relevant JAG initiated or compliant courses are mandatory (JAG compliant courses).

2. Education undertaken should recognise the differences in nurse and other non-medical endoscopists training and medical training and address the deficiencies to achieve a common core standard of knowledge in gastroenterology and endoscopy.

3. Education and courses should be part of the Higher Award Scheme for nurses, with standardised accreditation and transferability of training.

4. Nurse and other non-medical endoscopists may act as endoscopy trainers for both doctors and nurses once they have achieved:
   - Expert practice
   - Competency in the role
   - Undertaken appropriate Training the Trainers (Endoscopy) courses
RECOMMENDATIONS FOR TRAINING OF PAEDIATRIC ENDOSCOPISTS

The JAG recognises that the training requirements and experience required for Paediatric Endoscopy are different to those for the practice of adult gastrointestinal endoscopy. Pending the availability of formal validated assessment methods. Adult gastroenterologists undertaking endoscopies in paediatric patients should ensure that they have adequate training and experience and have trained in paediatric gastroenterology referral centres if intending to undertake paediatric endoscopy procedures post-CCST.

FACILITIES

1. Training in Paediatric Endoscopy must take place in units recognised by the RCPCH Speciality Advisory Committee on Paediatric Gastroenterology.

2. The training unit should be equipped with modern video endoscopy equipment suitable for use in paediatric practice. High quality televisial display and image recording facilities with access to training videos and ‘JPEG/MPEG’ programmes on the respective Paediatric Gastroenterology Society web pages.

ENDOSCOPIC EXPERIENCE

1. Trainees should undertake at least 100 diagnostic upper gastrointestinal endoscopies under supervision and at least 100 diagnostic ileo-colonoscopies pending the introduction of formal training assessment methods.

2. Trainees should have experience of removal of foreign bodies at upper gastrointestinal endoscopy and polypectomy at colonoscopy

3. After achieving competence at these procedures (Level 1) it is expected that higher level training will provide experience in and competence to perform a wide variety of therapeutic procedures (level 2). The accent is on ongoing skill assessment, i.e. qualitative rather than quantitative.

4. A written record of the number and variety of procedures carried out under supervision and subsequently independently should be kept for the trainee’s ‘procedure experience record’.

COURSES IN DIAGNOSTIC AND THERAPEUTIC PAEDIATRIC ENDOSCOPY

1. Trainees should attend courses in both diagnostic and therapeutic endoscopy.

2. Courses should be approved by the British Society of Paediatric Gastroenterology, Hepatology and Nutrition and be provided on a regional or national basis.

3. Basic courses covering the principles of endoscopic practice should be attended. These might be run purely for paediatric trainees, or in conjunction with a Basic Skills (Foundation) course initiated by or compliant with JAG standards (JAG compliant course). Specific areas where practice differs from adult endoscopy will need to be addressed.
GUIDELINES FOR COURSE ORGANISERS

WHAT IS THE FRAMEWORK FOR TRAINING?

1. Practical training will take place in defined Endoscopy Units which fulfill the criteria laid down for recognition in the JAG’s document.

2. It is a requirement of such training that the trainee should attend courses in defined areas of endoscopy.

3. The requirements for CME/CPD for trained endoscopists are not yet defined, but such training courses, as outlined above, are likely to contribute to CME/CPD for medical endoscopists.

4. For nurse or other non-medical endoscopists, the practical training aspects of upper GI endoscopy and flexible sigmoidoscopy will follow the guidelines laid down by JAG for training, but the mechanism of overall training is likely to be different from that of a medical endoscopist. It seems likely that university-based, validated modular courses for nurse endoscopists will be provided as part of a University degree course.

WHAT IS THE VALUE OF ENDOSCOPY COURSES?

1. Courses which are lecture and demonstration-based or those which are hands-on can contribute to specific areas of basic training for medical and non-medical endoscopists and for CME.

2. Courses can be used to supplement local training, to cover local deficiencies or to emphasise acceptable variety in practice.

3. Trainees as well as trained endoscopists should be encouraged to take advantage of training courses in order to supplement local experience.

WHAT ARE THE REQUIREMENTS OF TRAINING COURSES?

1. Courses other than those initiated by or compliant with JAG standards (JAG compliant courses) should be approved by the JAG and such approval should be sought using the appropriate form well in advance of advertising the course.

2. JAG would only recognise training courses provided by Endoscopy Units which fulfill JAG’s criteria for recognition.

3. The purpose of the training course should be clearly defined. Currently JAG recognises that courses may cover basic endoscopy, therapeutic endoscopy, patient care, maintenance, cleaning and disinfection of endoscopes and equipment, electrical hazards, recognition and management of complications and the general administration of an endoscopy unit. Practical aspects of therapeutic endoscopy are further defined to cover e.g. oesophageal stricture dilatation, oesophageal stenting etc. It seems unreasonable to insist that an endoscopy training course of perhaps one day’s duration should be wholly comprehensive, but the focus of any training course should be clearly defined, so that the contribution of the course to trainees’ overall experience can be evaluated (see pages 42-43 for further details of JAG courses).
EVALUATION OF ENDOSCOPY TRAINING COURSES

Some Endoscopy Training Units may wish to provide training courses for trainees from outside their own centre. This document is intended to provide guidelines and to set standards for course organisers wishing to develop courses outside those compliant by JAG.

DEFINITION OF TRAINING COURSE

Courses may be of different types. It would be sensible for a course organiser to discuss any proposed course with either the Lead in their Regional Endoscopy Training Centre or with the Lead in their responsible National Endoscopy Training Centre. It is important to realise that there are agreed nationally delivered JAG Courses (from Regional and National Centres) which are now mandatory for all trainee endoscopists, with set aims and curricula (JAG compliant courses). Local variations from these courses will be discouraged.

LIVE DEMONSTRATIONS

These courses are usually of one or two days in length and provide live demonstration by trainers in one or more aspects of GI Endoscopy. They may be supplemented by videotape demonstrations, short talks and seminars.

HANDS-ON COURSES

More intensive courses, usually with fewer attendees, providing supervised hands-on experience of a particular endoscopic technique.

LECTURE BASED COURSES

These courses are for a larger number of attendees and may be supplemented by videotape demonstrations and seminars but incorporate no live or hands-on component.

When applying for JAG approval, course organisers should indicate the type of course planned or give a description of their plans.

TARGET AUDIENCE

For each course, the organisers should stipulate the target audience, which should fall into one or more of the following groups:

- Novice
- Advanced beginner
- Competent
- Expert

Courses that are intended to target the expert or specialist audience are CME/CPD rather than training courses and it is anticipated that these courses will follow similar guidelines and standards.

Organisers should indicate the anticipated minimum and maximum numbers of attendees on the course.
COURSE CONTRIBUTORS

These should at least be members of a JAG approved unit or their staff, in the area of endoscopy to be covered by the course. National and international experts and specialists from other training centres can be invited to contribute and should be listed.

COURSE ENVIRONMENT

Live demonstration and hands-on courses should be run in a JAG approved endoscopy training unit, with the attributes and facilities this defines in terms of workload, multi-disciplinary philosophy, staff and equipment.

ADDITIONAL FACILITIES

Adequate accommodation must be available for the target audience in a suitable lecture theatre. For live or hands-on courses, CCTV and sound links must be provided.

COURSE MATERIALS

Documents which outline the aims and nature of the course, together with anticipated learning outcomes, should be provided. For live demonstrations and hands-on courses there should be written case histories. Handouts should be available to support lectures and seminars.

AIMS OF COURSE

The aims of the course should be defined in terms of course content (topics to be covered etc), the level of experience of the target audience (see above) and the learning outcomes (list the topics that attendees should know and understand after completion of the course). These aims should fit with requirements for training as outlined in the JAG recommendations especially if it is intended that the courses are to encompass any aspects of the JAG compliant courses.

COURSE PHILOSOPHY

It would be useful to know whether the planned course is a one off or whether it forms part of a structured series of training courses. If part of a series, a programme of courses should be provided.

POST COURSE EVALUATION

A form of evaluation of the course by attendees should be an inherent aspect of any course.

A specimen course evaluation form is available from the JAG office. Non-teaching aspects (comfort and catering) can be evaluated for the benefit of organisers who wish to improve for future courses.

Teaching aspects are evaluated by assessment of topics and speakers, as well as adequacy of fulfillment of learning outcomes (defined under aims of course).
## CURRICULUM FOR TRAINING IN ENDOSCOPY

### 1. GENERAL ENDOSCOPIC TRAINING

**OBJECTIVE:** TO PROVIDE TRAINEES WITH THE KNOWLEDGE AND SKILLS TO UNDERTAKE ENDOSCOPIC PROCEDURES SAFELY

<table>
<thead>
<tr>
<th>SUBJECT MATTER</th>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
<th>ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equipment</strong></td>
<td>Structure and function of an endoscope, light source, processor &amp; accessories including diathermy and thermal methods for coagulation</td>
<td>Able to clean and disinfect equipment in accordance with BSG guidelines and use equipment in accordance with manufacturers instructions</td>
<td>Willing to undertake endoscopy cleaning as necessary and use the equipment appropriately</td>
</tr>
<tr>
<td><strong>Consent</strong></td>
<td>Medical &amp; legal issues concerning consent and provision of information</td>
<td>Able to consent patient in accordance with BSG guidelines</td>
<td>Willing to obtain consent for endoscopic procedures</td>
</tr>
<tr>
<td><strong>Sedation and monitoring</strong></td>
<td>Sedative and analgesic drugs and their addative effects, patient observation and oxygen saturation</td>
<td>Able to safely and effectively sedate a patient for endoscopy and monitor before and after the procedure</td>
<td>Willing to participate in safe endoscopic practice.</td>
</tr>
</tbody>
</table>
## 2. UPPER GASTROINTESTINAL ENDOSCOPY

**OBJECTIVE:** TO PROVIDE TRAINEES WITH THE KNOWLEDGE AND SKILLS TO UNDERTAKE DIAGNOSTIC & THERAPEUTIC UPPER GASTROINTESTINAL ENDOSCOPY

<table>
<thead>
<tr>
<th>SUBJECT MATTER</th>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
<th>ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic gastroscopy</strong></td>
<td>Indications, contraindications, complications, patient preparation and documentation</td>
<td>Able to undertake OGD, take biopsies, interpret findings and take necessary action</td>
<td>Willing to undertake endoscopy in such a way as to minimise risk and discomfort to patients and obtain help when needed</td>
</tr>
<tr>
<td><strong>Endoscopic therapy of oesophageal strictures</strong></td>
<td>Methods for dilation of oesophageal stricture and insertion of prosthetic tube or expandable metal stents</td>
<td>Able to dilate oesophageal strictures and insert appropriate prosthetic devices</td>
<td>Willing to undertake therapeutic procedures safely and with minimum patient discomfort</td>
</tr>
<tr>
<td><strong>Thermal therapy of gastro-oesophageal tumours, ulcers and vascular malformations</strong></td>
<td>Laser and thermal methods for tumour ablation and control of bleeding lesions</td>
<td>Able to use thermal and laser methods during upper GI endoscopy</td>
<td>Willing to undertake therapy to reduce tumour bulk and stop or prevent bleeding and willing to obtain help when needed</td>
</tr>
<tr>
<td><strong>Direct injection/ banding techniques for bleeding lesions &amp; tumour therapy</strong></td>
<td>Endoscopic sclerotherapy/ banding of varices and injection of vasoconstrictor agents for arterial bleeding lesions, alcohol injection for tumour lysis</td>
<td>Able to perform injection sclerotherapy, band ligation and adrenaline and alcohol injection as appropriate</td>
<td>Willing to undertake therapy to stop or prevent bleeding, eradicate varices, reduce tumour bulk safely and obtain help when needed</td>
</tr>
</tbody>
</table>
3. LOWER GASTROINTESTINAL ENDOSCOPY

OBJECTIVE: TO PROVIDE TRAINEES WITH THE KNOWLEDGE AND SKILLS TO UNDERTAKE LOWER GASTROINTESTINAL ENDOSCOPY

<table>
<thead>
<tr>
<th>SUBJECT MATTER</th>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
<th>ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic total colonoscopy</td>
<td>Indications, contraindications, complications and their management, patient preparation and documentation</td>
<td>Able to undertake procedure and reach caecum in &gt;90% of cases where indicated. Take biopsies, undertake polypectomy &amp; take other necessary action as required.</td>
<td>Willing to undertake colonoscopy in such a way as to minimise risk and discomfort to patients and obtain help when needed</td>
</tr>
<tr>
<td>Flexible sigmoidoscopy</td>
<td>Indications, contraindications, complications and their management, patient preparation and documentation</td>
<td>Able to undertake procedure, take biopsies, undertake polypectomy &amp; take other necessary action as required.</td>
<td>Willing to undertake flexible sigmoidoscopy in such a way as to minimise risk and discomfort to patients, and obtain help when needed</td>
</tr>
<tr>
<td>Colonscopic therapy of tumours and strictures</td>
<td>Laser and thermal methods for tumour ablation and use of prostheses &amp; dilatation</td>
<td>Able to control tumour growth and recanalise colon as necessary</td>
<td>Willing to undertake therapy in such a way as to minimise risk and discomfort to patients and obtain help when needed</td>
</tr>
</tbody>
</table>
4. ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY

**OBJECTIVE:** TO PROVIDE TRAINEES WITH THE KNOWLEDGE AND SKILLS TO UNDERTAKE ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY [ERCP]

<table>
<thead>
<tr>
<th>SUBJECT MATTER</th>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
<th>ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERCP [see note 4 below]</td>
<td>Indications, contraindications, complications and their management, patient preparation and documentation. Endoscopies sphincterotomy and its complications, insertion and replacement of biliary stents, combined endoscopic and radiological procedures</td>
<td>Able to undertake ERCP and cannulate pancreatic and bile ducts in &gt;90% of procedures when deemed competent. Able to undertake sphincterotomy and stent insertion commensurate with their experience Able to identify the pupilla in &gt;95% of patients who have not undergone gastric surgery.</td>
<td>Willing to undertake ERCP in such a way as to minimise risk and discomfort to patients and obtain help when needed.</td>
</tr>
</tbody>
</table>
5. SMALL BOWEL ENTEROSCOPY

OBJECTIVE: TO PROVIDE TRAINEES WITH THE KNOWLEDGE AND SKILLS TO UNDERTAKE SMALL BOWEL ENTEROSCOPY

<table>
<thead>
<tr>
<th>SUBJECT MATTER</th>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
<th>ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small bowel enteroscopy [see note 4 below]</td>
<td>Indications, contraindications, complications and their management patient preparation and documentation</td>
<td>Able to recommend use of or undertake enteroscopy in suitable patients. Able to treat vascular lesions and polyps appropriately</td>
<td>Willing to refer patients to a colleague or specialist unit as necessary</td>
</tr>
</tbody>
</table>

6. ENDOSCOPIC ULTRASOUND

OBJECTIVE: TO PROVIDE TRAINEES WITH THE KNOWLEDGE AND SKILLS TO UNDERTAKE ENDOSCOPIC ULTRASOUND

<table>
<thead>
<tr>
<th>SUBJECT MATTER</th>
<th>KNOWLEDGE</th>
<th>SKILLS</th>
<th>ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endoscopic Ultrasound [see note 4 below]</td>
<td>Indications, contraindications, complications and their management. Uses of radial and linear array type scopes and range of therapy and biopsy possible with the latter.</td>
<td>Able to recommend use of or undertake endoscopic ultrasound in appropriate patients.</td>
<td>Willing to refer patients to a colleague or specialist unit as necessary</td>
</tr>
</tbody>
</table>
Notes:

1. Assessment methods for use with the curriculum are many and varied. Examples suggested include practical demonstrations by trainees, practice during training with simulators or accessories, observation during training lists, role-play and logbook details. These examples are not intended to be prescriptive. Educational supervisors are encouraged to be imaginative in the methods of assessment employed, provided they are relevant and robust.

2. Standards (measures) of competence can be derived from the main text in these guidelines however the JAG, working with the SAC in Gastroenterology issued firm guidance on standards in early 2002. These enable assessments to be carried out to a national standard. The use of the Logbook of Assessed Cases is recommended for all trainees and will be available from JAG.

3. For non-physician or surgeon trainees a JAG logbook of endoscopic experience may be obtained from the JAG office. This logbook will be developed and improved in conjunction with the standards document mentioned in note 2.

4. These procedures are not required techniques for all trainees. Where a trainee wishes to gain practical experience in these techniques, the minimum requirements are given in the main document.
ASSESSMENT OF COMPETENCE OF TRAINEES

1. In the initial (1999) JAG document, the main emphasis was to ensure that the trainees had enough supervised experience in each endoscopic skill. Thus units were required to declare the number of procedures performed to permit registration as a training unit.

2. Although implicit in the document, there were no statements as to the level of competence required before a trainee was signed off for each endoscopic skill.

3. In the second (2001) document the emphasis moved from numbers of procedures to expected endoscopic targets (e.g. caecal intubation rate in colonoscopy) as a measure of competence as well as further insistence of the number of cases supervised.

4. With respect to ERCP training, these two documents, together with an overall reduction in the numbers of ERCP's being undertaken, precipitated a statement issued jointly by the SAC in Gastroenterology and JAG that it was no longer essential that all trainees would be expected to undertake training in ERCP.

5. In addition, the JCHMT has recently requested revision of all the specialist curricula by the relevant SACs. As part of the review of the Gastroenterology curriculum, the endoscopy section was delegated to JAG by the Gastroenterology SAC.

6. As well as specifying various subjects that had to be covered in the curriculum, general guidelines on the possible assessment of competence of trainees were initiated. The Education department at the Royal College of Physicians of London in conjunction with the JCHMT and its constituent SACs is piloting a trio of assessment methods based on generic and procedure related skills assessment. There are three assessment methods being piloted, these being:

   - **Mini-CEX [clinical evaluation exercise]** was developed in the USA to assess the clinical skills that trainees most often use in real clinical encounters. It involves direct observation by an educational supervisor of a trainee’s performance in real clinical situations and is designed to assess skills such as history taking, clinical examination, communication, diagnosis and management of patients and their problems. It is repeated on multiple occasions with different patients in a variety of clinical settings and each episode should take 15-20 minutes.

   - **DOPS [direct observation of procedural skills]** is a method designed by the Royal Colleges of Physicians/JCHMT derived from the mini-CEX specifically to test procedural skills. The assessor observes the trainee, in a real situation. In addition to the assessment of the practical skills, DOPS also provides for the judgement of performance in some generic skills such as consent and communication. The JAG believes that DOPS is an ideal assessment method for assessing trainees in endoscopy and, assuming the pilots are successful, will be recommending its adoption within the training of endoscopists.

   - **360° assessment** is a method designed to assess behaviours and involves the systematic collection and feedback of performance data on an individual derived from a number of stakeholders on his/her performance. ‘Raters’ [ie those given the task of assessing the trainee] will include peers, other allied professionals, lay colleagues and so on. 12 to 15 raters would be needed on each occasion.

7. Assuming the successful conclusion of the pilot project, it is anticipated that these assessment methods will be taken into use by all ‘Physician’ disciplines including gastroenterology. However, in the meantime, JAG considers that there is a valuable opportunity to take up the DOPS concept by taking advantage of each learning experience trainees are exposed to. As trainees are supervised, case by case, each part of the endoscopic process can be assessed, thus enabling the trainee to build up a portfolio of assessed cases instead of simply keeping a logbook of cases undertaken.

8. From a variety of sources, a list of the individual assessable skills in undertaking an endoscopy has been put together so that for each supervised endoscopy the trainee can be
observed in a structured manner. This has been piloted and does not add any significant time to the supervising trainer duties, but allows a systematised assessment of the trainee’s performance over a variety of domains. Thus instead of just overseeing the procedure, the trainer’s attention is drawn to each aspect of the procedure both generic, such as interpersonal skills and actual manual skills.

9. This case by case scoring provides firm documentary evidence for completion of training and assessment of competence, which will undoubtedly prove invaluable in this litigious world.

10. An assessment sheet that has been piloted with a further summative assessment sheet for the end of an attachment, or to enable a particular endoscopic skill to be signed off, has been tried in several hospitals. These are reproduced here on the following pages as examples of the detailed assessments that will be required by the statutory bodies in the near future. These types of form should form the basis of RITA assessments for medical trainees as far as endoscopy is concerned.
## ENDOSCOPY TRAINEE ASSESSMENT SHEET

**DATE** .......................................................... **TRAINER** .......................................................... **TRAINEE** ..........................................................

<table>
<thead>
<tr>
<th>Procedure Type (see list)</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
<th>Case 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed (o) / Assisted (a) / Independent (i)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Understanding Indication

- Consent: Procedural explanation
- Consent: Risk explanation

### Administration of Sedation

### Equipment Check (pre-Endoscopy)

### Intubation skills

- OGD
  - Scope handling
  - Oesoph Intubation
  - Duodenal Intubation
- COLON
  - Scope handling
  - Torque steering
  - Loop Recognition
  - Loop Resolution
- Caecal (c) ileal (I) Intubation

### ERCP

- Scope handling
- Oesoph Intubation
- Duodenal Intubation
- Papilla Identification
- Desired duct achieved (b/p)

### Mucosal Visualisation

### Diagnostic ability

### Selection of Accessories and Use

### Therapeutic Abilities

### Flush Channels after Scope

### Recognition & Management of Complications

### Report Writing

### Appropriate FU/treatment

### Recommendations

### Communication with Patient/Relative

### Communication/Relations with Staff

### Use of Safe X-ray screening

### Image Interpretation

### Diagnosis/Comment

---

**Procedure List:**
- OGD=O, Dilat=D, StentInsertion=SIO, VaricesBand=VB, VaricesInject=VI, Bleed Inj=BI, Bleed Thermal=BT, F.Sigy=FS, Colon=C, Polypectomy=P
- ERCP=E, StoneExt=SE, StentInsertion=SIE, Other=OT

**Assessment of skill:**
- Inadequate requires constant supervision=1
- Adequate but needs focused training=2
- Competent=3

---

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### JAG SUMMATIVE PROCEDURAL ASSESSMENT - (FINAL)

<table>
<thead>
<tr>
<th></th>
<th>Competent*</th>
<th>Needs focused training</th>
<th>Inadequate requires constant supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>GASTROSCOPY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Diagnostic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GASTROSCOPY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Dilatation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Variceal Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Bleeding Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Stent Insertion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ PEG Insertion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Tumour Debulking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COLONOSCOPY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Polypectomy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Laser</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ EMR</td>
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<td></td>
</tr>
<tr>
<td>ERCP</td>
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<tr>
<td>+ Diagnostic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Stent Insertion</td>
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<td></td>
</tr>
<tr>
<td>+ Stone Removal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Other ( )</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SMALL BOWEL ENTEROSCOPY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ENDOSCOPIC ULTRASOUND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Oesophagus/Stomach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Hepato-pancreato-biliary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Diagnostic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ Therapeutic</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* See JAG & SAC Guidelines

### COMMENTS:

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Signature Assessor: __________________________  Signature Trainee: __________________________
JAG COMPLIANT COURSES

1. In the 2001 JAG document it is laid down that both trainees and trainers should undertake appropriate courses.

2. Trainees are required to attend a Basic Skills (Foundation) Course in Upper Gastrointestinal Endoscopy. If they were to pursue other types of endoscopy then attendance at courses related to each endoscopic skill were to be undertaken. Courses in Colonoscopy, Therapeutic Upper Gastrointestinal Endoscopy, Flexible Sigmoidoscopy and ERCP are specifically mentioned. A course for Endoscopic Ultrasound is also being developed. For the trainers, a Training the Trainers (Endoscopy) course is mentioned.

3. It was appreciated that within the lifetime of the 2001 document not all the courses would be established, nor was it likely that all, or even most of the trainees and trainers would have been able to attend them.

4. The JAG, after much discussion, commissioned the Raven Department of Education at the Royal College of Surgeons of England to develop the courses with the intention that they would be ‘franchised’ out to the regions along the lines of the Basic Surgical Skills Course or the ATLS course.

5. In line with the Raven Department policy, a steering group chaired by Professor Jack Hardcastle, was established and individual course development working parties started. Membership of each working party and the steering group was deliberately chosen to represent the relevant interested bodies including the JAG.

6. Thus membership from the JCHMT and JCHST in the form of members of the relevant SACs together with core members from JAG and the BSG Endoscopy Committee were supported by members from the Royal Colleges of Physicians, Surgeons, General Practice, Paediatrics and Child Health and Radiology as well as The Royal College of Nursing. Additional members were drawn to represent various specialist societies such as AUGIS, ACP and TIGS.

7. Most of the sub-committees have been led by Mr Roger Leicester and the Chairman of JAG has been present on all groups.

8. Using as a model the ‘Hands on Colonoscopy course’ pioneered by Charles Swan at Stoke on Trent, the first course to be developed has been the Basic Skills in Colonoscopy course.

9. The second course to be rolled out was the Basic Skills (Foundation course) in Endoscopy.

10. Alongside the development of these courses and with the help of Mr Rodney Peyton and Ms Elizabeth Hoadley-Maidment (Educationalists), a Training the Trainers (Endoscopy) course has been piloted and is now being delivered from several centres.

11. The Flexible Sigmoiodoscopy course has been piloted and the Therapeutic Upper Endoscopy course is in an advanced state of planning with the handbook now completed. The faculty for the ERCP course has been selected and work on this course will soon ensue.

12. In order to cascade out the courses, several centres had to be enrolled to increase the availability of places. Until March 2000 no money had been found for these developments and again through the efforts of Mr Leicester a proposal for funding from the National Cancer Plan was put forward and accepted by the Department of Health.

13. This has provided the starting funds to develop the above courses and to enable various centres to offer the courses. This funding ends at the end of March 2004.
14. Of the two remaining courses to be finalised before piloting (Therapeutic Upper Endoscopy and ERCP) the Council of the BSG has provisionally agreed to help fund their development up to and including the piloting stage.

15. As of June 2003 the groups have developed the following courses:
   - Basic skills in Colonoscopy
   - Basic skills (Foundation course) in Endoscopy
   - Training the Trainers (Endoscopy)
   - Flexible Sigmoidoscopy
   - Therapeutic Upper Endoscopy group has started work but course not finalised
   - ERCP working group selected to start work shortly.

CONTENT OF JAG COMPLIANT COURSES

16. Each course consists of a basic theory part as well as hands on skills training in the relevant endoscopic area. Each course has evolved during the piloting stage to ensure that they deliver the essential educational activity and practical skills training.

17. The precise details of each course are beyond the scope of this document, however, a brief summary is included to give a guide to the format of the courses.

18. Each course, wherever taught, has the same syllabus, and regular participation from the visiting faculty is built into the programme to prevent any centre from deviating significantly from the agreed format.

19. In the fullness of time, when the courses are widely available, it is intended that each endoscopist should undertake the Basic Skills (Foundation course) in Endoscopy at the start of their endoscopic career and then undertake the individual more specialised courses as they train in each skill. When this happens, many of the more generic topics such as diathermy, safety and sedation, cleaning etc will be removed from the later courses.

BASIC SKILLS (FOUNDATION COURSE) IN ENDOSCOPY

20. This course is a 3-day course with the first 2 days devoted to the theory and background of the practice of safe endoscopy, as well as the training in the basic skills of upper gastrointestinal intubation and flexible sigmoidoscopy. To enable the skills training to be practiced, endoscopic models are used, complemented by use of the latest computer simulators.

21. On the third day each trainee undertakes 3-5 Upper Gastrointestinal Endoscopies on sedated patients who have given their prior informed consent.

22. Between 8 and 12 trainees can participate in the course and this requires 4 trainers. The theoretical aspects include:
   - Instrument design and function
   - Indications and contraindications
   - Complications, their avoidance and management
   - Informed consent
   - Safe sedation
   - Diathermy theory and practice
   - Accessories and sample handling
   - Equipment fault finding
   - Cleaning and disinfection
   - Unit management and organisation (including Modernisation Agency Endoscopy Project details).
The practical skills taught include:-

- Control Handling
- Torque steering
- Retroversion in the stomach
- Loop recognition and resolution during flexible sigmoidoscopy

BASIC SKILLS IN COLONOSCOPY

23. This is a 3-day course with a mixture of theory as in the above course together with skills training in torque steering using models. Additional topics include Polypectomy and Surveillance protocols.

24. Each of the 4 trainees undertakes 4 colonoscopies under direct supervision of a trained consultant trainer. Each training centre running such courses has specifically designed split screen video projection facilities so that the other trainees can benefit from the training of their colleague. The training experience is complemented by the use of the 3D magnetic imager to help the trainee understand loop development and resolution. Each course requires 3 trainers.

BASIC SKILLS IN SIGMOIDOSCOPY

25. The first pilot of this course was run in February 2003. The theory part is the same as that for the Colonoscopy course with appropriate alterations to the indications, contraindications and complications.

26. Skills training were also similar to that of the colon course with the use of the same models. It is planned that the course will run over three days, with each trainee undertaking 4 flexible sigmoidoscopies in appropriately consented and sedated patients. 3 trainers will be required for 6 trainees.

TRAINING THE TRAINERS (ENDOSCOPY) COURSE

27. This course is run over 2 days with the first day being an intensive course on the principles of adult education and in particular training in the principles and practice of skills training. On the second day, the trainee trainers concentrate on skills training in endoscopy with particular reference to scope handling and torque steering. The structure and content of this course is likely to undergo change as increasing numbers of trainers have attended generic “Training the Trainer” courses. More emphasis on assessment of trainees is to be introduced.
INITIAL TRAINING CENTRES DELIVERING
JAG COURSES (TO APRIL 2004)

1. In order to deliver the JAG compliant courses in a standardised manner, it was decided that any centre wishing to undertake the courses would have to be inspected to make sure that the training environment was appropriate, that the nursing and support staff were committed to undertaking the courses and that the requisite facilities were available. The minimum requirement is for an on-site seminar room to be attached to the endoscopy unit and that the unit is equipped with modern video endoscopy.

2. Once approved by an inspection team representing JAG and the Raven Department of Education, a standardised audiovisual kit was installed, funded initially by the Beating Bowel Cancer charity and subsequently by the Department of Health.

3. Two categories of training centre have been established with funding according to the number of courses undertaken. Full time centres have to undertake to run 10 colonoscopy courses per year, while part time centres run 3 courses. The current funding relates to provision of colonoscopy courses only but the other courses have been piloted and run by the original group of training centres.

4. Each centre has to have enough faculty who have undertaken the Training the Trainers (Endoscopy) course to staff the majority of their courses, the additional faculty being made up by established trainers from other designated units. This allows for continuing conformity with the structure and ethos of the courses.

5. The full-time centres were;
   - The Mersey School of Endoscopy (at the Royal Liverpool University Hospital)
   - St. George’s Hospital

6. The initial part-time centres were;
   - Wolverhampton
   - Torbay
   - Nottingham

   (Both Wolverhampton and Torbay expected to become full-time centres prior to introduction of the new training initiatives (pages 44-45).

7. New established part-time centres
   - Middlesborough
   - Hull (Castle Hill Hospital)
   - Sheffield
   - Norwich
   - Brighton

   In addition, Gloucester and Leicester have started to deliver training courses.

8. This programme was funded by the National Cancer Plan and the funding is due to cease at the end of March 2004.

9. A new Department of Health funded programme has been introduced this year and details are given in paragraph 6 on page 45 in the next section.
NEW TRAINING INITIATIVES FROM APRIL 2004

1. The JAG is aware that many units around the UK put on high quality training both as hands-on training and as endoscopy courses.

2. In the past JAG has approved many of these courses on the basis of provided documentation and reputation. It rapidly became clear that in addition to the courses that were already being provided, specifically designed and nationally deliverable standardised courses were needed with the formalisation of training curricula. Thus the previously discussed JAG courses came into being. The other individually designed and delivered courses continually asked JAG to approve their format. After much discussion at JAG it was felt that it would be difficult to approve a course that had not been visited and thus we opted to vet submitted courses on the basis of the provided documentation. Now that JAG’s own prescribed suite of courses is almost completely established, we will return to the practice of approving suitable courses, making it clear whether or not the course is initiated by or compliant with the standard JAG courses (JAG compliant course) or whether it is simply approved.

3. We therefore suggest the following terminology is used;-
   - **JAG compliant course** (Basic Skills Foundation etc) initiated by and/or compliant with JAG course standards.
   - **JAG Approved** - not initiated by or compliant with the JAG courses, but reaching adequate educational/training standards (NB. not a substitute for compulsory attendance at JAG compliant courses)

4. The JAG is fully aware that there has been a marked increase in the use of endoscopy training models and simulators. However at this present time these innovative approaches are not thought to be an adequate substitute for the training of endoscopists to the standards of JAG or the relevant SAC’s. It may be with time and improvements in simulators that they may play a mandatory part in the training of endoscopists, but it is the view of JAG that as yet their role is to be determined.

5. The JAG is also aware that there has been a concentration of training on skills, and little attention to lesion recognition. It is therefore planned that a library of endoscopic pictures is developed and an e-assessment method be introduced. Thus trainees will log onto the assessment site and view and diagnose a set of endoscopic pictures that can then be marked by computer and a certificate of competence in ‘lesion recognition’ issued. This of course might ultimately be one aspect of the revalidation process for endoscopists. The Chairman, on behalf of JAG, has been in discussion with a commercial e-education company re-developing this model and has applied for funding.

6. Perhaps of even more importance is the recent announcement that the Department of Health through the Cancer Plan has allocated £9M over three years for endoscopy training. The North East London Workforce Development Confederation [WDC] has been given the task of developing a training plan for endoscopy. The WDC has already invited tenders for both national and regional Training Centres. This initiative currently only applies to England. JAG and the SAC (Gastroenterology) have written in support of similar funding to the funding bodies in Scotland, Wales and Northern Ireland.

7. 3 national Training Centres (Liverpool (Mersey School of Endoscopy), St George’s and St Mark’s) and 7 regional centres (Middlesborough, Hull, Sheffield, Norwich, Wolverhampton, Torbay and Gloucester) have been appointed. Full details are appended at pages 41 and 42.

8. Several other centres have submitted bids for training centre status, and it is hoped that until funds are available these aspirant centres will work closely with the national and regional centres to promulgate good endoscopy training throughout the country.

9. The funding that is available continues from the Raven Department initiative and will be until April 2007.
10. It is anticipated that the national centres will each have a ‘pastoral’ role in supporting several regional centres, as well as taking a lead in the development of new courses or specific areas of endoscopy.

11. It is the view of JAG that all the new centres will deliver some or all of the required mandatory JAG compliant courses in order to ensure that all trainees will have access to these required courses.

12. The details of the educational supervision of the courses is not yet clear but JAG has been assured that it will be consulted on such matters. Discussions have to date indicated that the work undertaken by JAG has been acknowledged as important and it is the stated intention that the standards set by JAG are to be adhered to.

13. It thus looks at last as though the Department of Health is taking both endoscopy services and training seriously which we believe is only to the benefit of patients.
RE-REGISTRATION OF ENDOSCOPY TRAINING UNITS FROM APRIL 2004

BACKGROUND

1. The registration of training units was one of the core responsibilities given to the JAG by the Conference of Medical Royal Colleges at the inception of JAG.

2. Initially this was undertaken as a paper exercise, with each unit’s lead clinician being asked to:
   - certify that the unit performed more than the JAG specified number of procedures of each type to gain registration and
   - that the unit conformed to the listed JAG standards. Units were also asked to list the endoscopists concerned in training and the number of trainees.

3. It has since become apparent that this simplistic approach, relying predominantly on throughput did not allow for any measure of quality of the training environment, or even the number of cases available per trainee.

4. The second JAG document for the first time hinted that for re-registration, at least one trainer should have attended a Training the Trainers (Endoscopy) course and eventually all trainers would be expected to complete such a course.

5. In addition, this document stressed the importance of quality of endoscopic practice and compliance with accepted national (predominantly BSG) guidelines.

6. However, as a result of recent SAC in Gastroenterology visits and other information gleaned from a variety of sources including trainees, it has become apparent that not all units are complying with acceptable standards of care. It is clear that for re-registration to have any validity more rigorous requirements must be met.

7. In the last two years the Modernisation Agency and the National Patient Access Team have highlighted the need for improvements in endoscopy units performance, to reduce waiting times, increase throughput and improve the quality of the patient’s journey. To this end a ‘toolkit’ has been piloted which has demonstrated that considerable improvements can be made in the endoscopy services that are offered. A clinical lead for the endoscopy project has been appointed (Dr R Valori) and shortly each strategic Health Authority will have a sessional commitment from regional leads to roll out the endoscopy project.

8. Thus, for perhaps the first time, both the profession and the Department of Health are focusing on the endoscopy services that exist and are the basis for endoscopy training.

9. JAG has decided, after discussions with the SAC in Gastroenterology and with the approval of the Federation of Royal Colleges that site visits to each registered training unit would be made prior to re-registration. It is envisaged that, where at all possible, such site visits will be undertaken by the SAC in Gastroenterology with JAG representation, but where such site visits are not yet planned by the SAC, JAG will make visits on a regional basis with the support of members of the SAC, BSG Training Committee and with the help of the local Gastroenterology Training Programme Directors.

10. Similar visits have been made in some regions and have involved two visitors attending for from a few hours to a half day per unit. If the visit is being made to the Programme Director’s own unit then a deputy or other visitor will need to be selected.

11. It is envisaged that the visitation will be made by the Regional Programme Director (representing the Deanery) with another consultant with an interest in endoscopy (gastroenterologist, surgeon or radiologist) preferably from the same region. This other endoscopist ideally should be a member of the SAC, JAG or the Training Committee of the
BSG. If there is no such individual then a colleague representing these bodies from an adjacent region should be approached.

12. In addition, a training representative from the local Regional or National Endoscopy Training Centre (the Lead or Deputy) and a Senior Nurse from the Centre will be invited to ensure that training needs of, and support for the visited unit can be organised.

13. The Endoscopy Lead for each Strategic Health Authority under the Modernisation Agency mentioned above should be included in this scheme to reduce the number of visits to units. This will ensure that training and service delivery are seen as interlinked areas of endoscopy.

14. Each regional Programme Director in Gastroenterology will be responsible for arranging the programme of site visits on or near the anniversary of expiry of the units’ current JAG registration (details to be provided by JAG).

15. It is intended that each Programme Director will receive the list of registered units in that region together with the registration dates from the JAG secretariat.

16. Three months prior to the intended visit date, a detailed questionnaire will be sent to the consultant in charge of the unit. This document will form the basis of the evidence for re-registration and will have to be formally signed off by both the lead Clinical Director and the Nurse Manager.

17. Each training unit will be responsible for the costs of such visits, however, as these will be on a regional basis this should simply reflect travel costs and the usual hospitality and not involve overnight accommodation.

18. It is clear that the training environment provided for the trainees, in its broadest terms should be assessed including compliance with nationally accepted standards of endoscopy including such matters as cleaning and disinfection of endoscopes and accessories, safe sedation techniques and monitoring and other matters of structure including adequate recovery space, access to resuscitation equipment, piped oxygen etc.

19. It may be, that in future, only units which follow the Modernisation Agency programme of improved efficiency will be thought suitable for training.

20. The approval of the widening of JAG’s remit to include site visits is not designed to lessen the authority of the relevant SAC’s but to assist JAG in ensuring that the re-registration is completed in a timely manner and that units do actually meet the requirements.

21. These visits will enhance the supervision of the SAC’s curriculum in that the SAC will know that the infrastructure is appropriate to the unit being a training unit.

22. When visits have been made, local consultants have nearly always found them of help in dealing with local funding or staffing issues. The close ties with the SAC are essential to provide the statutory backup with the threat of non-compliant units having their training status withdrawn.

23. In the current environment of clinical governance and litigation, JAG is of the opinion that failure to undertake site visits would render the process of re-registration invalid and JAG liable if litigation were to ensue in a JAG registered unit.

24. Including the local Modernisation Agency Endoscopy Lead in such visits would enhance the move to training in functionally modern units who should be following accepted best practice.
JAG REGISTRATION AND RE-REGISTRATION QUESTIONNAIRE

NAME OF UNIT:
.....................................................................................................................................................................

JAG REGISTRATION NUMBER:
.....................................................................................................................................................................

NAME OF CONSULTANT IN CHARGE:
.....................................................................................................................................................................

STRUCTURAL DETAILS

1. Is there a scope cleaning room/rooms separate from the endoscopy rooms? Yes/No

2. Are there separate waiting and recovery areas? Yes/No

3. Are there facilities for trolley and seated recovery? Yes/No

4. Are there separate reception facilities for outpatients and inpatients? Yes/No

EQUIPMENT DETAILS

1. Are video-endoscopes used for the majority of procedures? Yes/No

2. Are there facilities for image capture and printing? Yes/No

3. Is there a computerised data recording system? Yes/No

4. Is a resuscitation trolley available within the unit? Yes/No

5. Is piped oxygen available both within the endoscopy rooms and the recovery area? Yes/No

6. Is pulse oximetry available within the endoscopy rooms and the recovery area? Yes/No

7. Is equipment available for the endoscopic cessation of bleeding? Yes/No

8. Are safe facilities available for radiographic screening for appropriate cases? Yes/No
STAFFING

1. Are there dedicated reception and clerical staff? Yes/No

2. Does the unit comply with BSG guidelines on the staffing of endoscopy units? Yes/No
   (i.e. 2 staff per room, 1 of whom should be a trained nurse, for ERCP 3 staff)

3. Are there adequate numbers of nursing staff for the reception and recovery areas? Yes/No

4. Are there adequate numbers of staff to clean and disinfect the endoscopes? Yes/No

POLICIES AND DOCUMENTATION

1. Are the national DoH/NHS consent forms used? Yes/No

2. Are information leaflets available for all the endoscopic procedures? Yes/No

3. Are standardised endoscopy reporting forms available (in those units without a computerised record system)? Yes/No

4. Are the following BSG guidelines followed:
   - Informed consent Yes/No
   - Safety and sedation Yes/No
   - Cleaning and disinfection Yes/No
   - Antibiotic prophylaxis Yes/No

5. Are there policies for patients with diabetes, renal failure and patients on anticoagulants (documents will be inspected at site visit)? Yes/No

6. Are there policies for the safe discharge of patients? Yes/No

7. Are there clear instructions for patients and their carers if post endoscopy complications should arise? Yes/No

8. Are there policies available for the surveillance of appropriate patients? Yes/No

9. Is the unit using/adopting the toolkit of the Modernisation Agency Endoscopy Project to improve service delivery? Yes/No

10. Is there a system for documentation of complications and 'near miss' problems? Yes/No
LIST SIZES AND PATIENT NUMBERS

1. Are there designated training and service lists?  Yes/No

2. What is the average number of patients scoped per list?

   Service:  OGD .......................  Colon .................  FSig ......................  ERCP .....................

   If mixed lists approximate numbers:

   Service:  OGD .......................  Colon .................  FSig ......................  ERCP .....................

3. Are there sufficient patients to allow each trainee to follow the JAG recommendations?  Yes/No

4. Are there sufficient patients to permit trainers to maintain their endoscopic competence as well as enough to meet training needs?  Yes/No

TRAINING ENVIRONMENT

1. Is there a designated consultant in-charge of training?  Yes/No

   Please print name:

   .....................................................................................................................................................................

2. How many consultant trainers are there attached to the unit?  .................

3. How many have undertaken the JAG approved “Training the Trainers (Endoscopy)” course

   Please list their names:

   .....................................................................................................................................................................

   .....................................................................................................................................................................

4. Is there a teaching/seminar/training room in or near the endoscopy unit?  Yes/No

5. Are there any endoscopy models or simulators available?  Yes/No

   Please state their type:

   .....................................................................................................................................................................

6. Are trainees trained in a multi-disciplinary environment as stated in the JAG document?  Yes/No

7. Are trainees supervised for the required minimum number of cases as stated in the JAG document?  Yes/No
8. Are formal assessments of competence for each endoscopic procedure/process made along the guidelines issued by the SAC Gastroenterology and JAG? Yes/No

9. Are all trainees, irrespective of their background discipline, trained to the same standard? Yes/No

10. Is formal training in the following aspects of endoscopy given to all trainees?

   - Obtaining consent Yes/No
   - Indications and contraindications Yes/No
   - Safety and sedation Yes/No
   - Antibiotic prophylaxis Yes/No
   - Diathermy safety and technique Yes/No
   - Complications and their management Yes/No

11. Are trainees encouraged to attend JAG approved courses? Yes/No

12. Does your unit run endoscopy related courses? Yes/No
   If so please state their title:

   ....................................................................................................................................................................

13. Is there a programme of regular audit on endoscopic matters? Yes/No

14. Can the visiting team help the unit to improve the patient's Endoscopy experience and if so how?

   .....................................................................................................................................................................

Certification
We, the undersigned confirm that the details given in the above questionnaire are true.

.....................................................................................................................................................................

Clinical Director/ Consultant in charge

.....................................................................................................................................................................

Directorate/Unit Nursing Manager/Nurse in charge

.....................................................................................................................................................................
REGISTRATION OF TRAINING UNITS, TRAINEES AND LOGBOOKS

The table below sets out the forms required by units and trainees registering or reporting to the JAG:

1. Units wishing to register with the JAG in one or more of the modalities of training should complete Form A and submit it to the JAG office.

2. Trainees from disciplines other than Gastroenterology or General Surgery should enrol with the JAG on Form G.

3. Those seeking the approval or recognition of courses must complete Form H and submit this to the JAG office, Form I is to be submitted following the course taking place.

4. A JAG logbook of endoscopic experience, assessment and certification, is available for trainees for whom SAC logbooks are not available i.e. those trainees not in Gastroenterology or General Surgery training.

<table>
<thead>
<tr>
<th>Event</th>
<th>Document/Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration of unit(s) for endoscopy training</td>
<td>Form A</td>
</tr>
<tr>
<td>Completed by the consultant in charge of endoscopy training</td>
<td>See pages 36-39</td>
</tr>
<tr>
<td>Registration form for trainees</td>
<td>Form G</td>
</tr>
<tr>
<td>For use by Radiologists, GPs or Nurse Practitioners</td>
<td></td>
</tr>
<tr>
<td>Application for the accreditation of an endoscopy course.</td>
<td>Form H</td>
</tr>
<tr>
<td>For completion by course organisers</td>
<td></td>
</tr>
<tr>
<td>Specimen course evaluation form</td>
<td>Form I</td>
</tr>
<tr>
<td>JAG logbook</td>
<td>JAG logbook</td>
</tr>
</tbody>
</table>

The above forms are available from the website [http://www.thejag.org.uk/] or from the JAG office in hard copy, by disk or e-mail:

JAG Secretariat
5 St Andrews Place
Regents Park
LONDON
NW1 4LB

Tel: 020 7935 1174 Ext 513/437
Fax: 020 7486 4160
## Appendix A

### National Centres

<table>
<thead>
<tr>
<th>Centre Lead</th>
<th>Title</th>
<th>Contact Name</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST, Prescot Street, Liverpool L7 8XP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor Anthony Morris</td>
<td>Consultant Gastroenterologist &amp; Director of Endoscopy</td>
<td>Michelle West</td>
<td>0151 706 2806 <a href="mailto:Michelle.West@rlbuht.nhs.uk">Michelle.West@rlbuht.nhs.uk</a></td>
</tr>
<tr>
<td>Mr. Roger Leicester</td>
<td>Consultant Surgeon</td>
<td>Pat Parish</td>
<td>0208 725 1563 ex 0771 <a href="mailto:pat.parish@stgeorges.nhs.uk">pat.parish@stgeorges.nhs.uk</a></td>
</tr>
<tr>
<td><strong>ST GEORGE’S HEALTHCARE NHS TRUST, St George’s Hospital, Blackshaw Road, Tooting SW17 0QT</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Brian Saunders</td>
<td>Consultant Gastroenterologist</td>
<td>Lisa Mackay</td>
<td>0208 235 4225 <a href="mailto:l.macay@imperial.ac.uk">l.macay@imperial.ac.uk</a></td>
</tr>
</tbody>
</table>
### Regional Centres

<table>
<thead>
<tr>
<th>REGIONAL CENTRES</th>
<th>ADDRESS</th>
<th>CONTACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GLOUCESTERSHIRE HOSPITALS NHS TRUST, Gloucester Royal Hospital, College Lawn, Cheltenham, Gloucester. GL53 7AN</strong></td>
<td>Dr John Anderson Consultant Physician &amp; Gastroenterologist Rebecca Brown 08454 226727</td>
<td></td>
</tr>
<tr>
<td><strong>HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST, Castle Hill Hospital, Castle Road, Cottingham, E Yorks HU16 5JQ</strong></td>
<td>Dr Graeme Duthie Reader in Surgery Stephanie Roe 01482 623247 <a href="mailto:s.roe@hull.ac.uk">s.roe@hull.ac.uk</a></td>
<td></td>
</tr>
<tr>
<td><strong>NORFOLK AND NORWICH UNIVERSITY HOSPITAL TRUST, Colney Lane, Norwich, Norfolk NR4 7FP</strong></td>
<td>Dr Richard Tighe Consultant Gastroenterologist Annie Cook 01603 286836 <a href="mailto:annie.cook@nnuh.nhs.uk">annie.cook@nnuh.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td><strong>SHEFFIELD TEACHING HOSPITALS NHS TRUST (STH), Dept of Gastroenterology, Northern General Hospital, Herries Road, Sheffield S5 7AU</strong></td>
<td>Dr Stuart Riley Consultant Gastroenterologist Lynne Greetham 0114 2266072 <a href="mailto:Lynne.Greetham@sth.nhs.uk">Lynne.Greetham@sth.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td><strong>SOUTH TEES HOSPITALS NHS TRUST, Marton Road, Middlesborough TS4 3BW</strong></td>
<td>Professor Mike Bramble Dr John Silcock Consultant Gastroenterologist Consultant Gastroenterologist Johanna Buckton 01642 854846 <a href="mailto:Johanna.buckton@stees.nhs.uk">Johanna.buckton@stees.nhs.uk</a></td>
<td>Appendix A</td>
</tr>
<tr>
<td><strong>SOUTH DEVON HEALTHCARE TRUST, Torbay Hospital, Torquay TQ2 7AA</strong></td>
<td>Dr Robin Teague Consultant Gastroenterologist Linda Beard 01803 654826 <a href="mailto:Linda.Beard@nhs.net">Linda.Beard@nhs.net</a></td>
<td></td>
</tr>
<tr>
<td><strong>THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST, New Cross Hospital, Wolverhampton, WV10 0QP</strong></td>
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