Endoscopy Operational Policy

Department / Service:	Endoscopy	
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Approved by:	Endoscopy Directorate Group SCSD Governance Meeting	
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust	
Target Departments	Endoscopy	
Target staff categories	All Endoscopy staff	

Policy Overview:
This policy outlines the processes followed in Endoscopy and provides reference material on these processes. This policy applies to all Endoscopy staff and all multi-disciplinary teams involved with Endoscopy across the county. JAG requirements are referenced throughout the policy and processes set to follow JAG standards.

Key Amendments made to this document

Date	Amendment	Approved By:
March 2013	New Policy	
25/04/2016	Document extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
August 2017	Document extended for 6 months as per TMC paper approved 22nd July 2015	TMC
December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
October 2018	Revised policy document rewritten. Previous authors names removed. Document approved for two years at SCSD Governance Meeting	SCSD Governance Meeting
April 2021	Policy Revised and approved	SCSD Governance Meeting
16th April 2024	Document extended for three months.	Karen Macpherson
1st August 2024	Document extended for 6 months whilst under review	Karen Macpherson
2nd October 2024	Policy revised, and content rewritten to meet new standards from JAG. Previous authors names removed.	Endoscopy Directorate Meeting

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1. Introduction

This policy outlines the operational procedures, guidelines, and standards essential for delivering high-quality endoscopy services within the Worcestershire Acute Hospitals NHS Trust (WAHT). Our aim is to ensure patient safety, promote effective clinical practices, and maintain a consistent approach to endoscopy across all levels of staff involvement. This policy has been developed in line with current best practice, ensuring that our services meet the highest standards of care and regulatory compliance. By adhering to this policy, we aim to provide a seamless, efficient, and patient-centred experience for all individuals undergoing endoscopic procedures.

2. Scope of this document

2.1. This policy applies to all staff involved in countywide endoscopy services: Alexandra Hospital, Redditch; Evesham Community Hospital; Kidderminster Treatment Centre; Malvern Community Hospital; and Worcestershire Royal hospital.

2.2. This policy is a guide to users and covers the main objectives of the Endoscopy Service and is based on guidance from national documents.

2.3. The intention of all documents linked to this operational policy is to advance the practice of Endoscopy services provided in the Trust to the levels and quality required by national guidelines and to surpass these requirements wherever possible. This policy supports standards set out by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) and aims to continuously achieve high standards.

2.4. The Operational policy will be supplemented with guidelines, standards and protocols prepared by the individual clinical disciplines, endoscopy staff and management, and the Trust Board.

2.5. This document relates to all procedures undertaken in the countywide endoscopy service, diagnostic or therapeutic.

2.7. This policy also includes activity undertaken by insourcing or locum teams within WAHT, as well as any other staff associated with Endoscopy.

3. Definition of key terms

AGH	Alexandra General Hospital
BCSP	Bowel Cancer Screening Programme
DATIX	Incident reporting system
Day case	A patient elected to be admitted during the day with intentions of receiving care, who is not intended to require the use of a hospital bed overnight and returns home as scheduled.
Diagnostic	Diagnostic test is a medical test performed to aid in the diagnosis or detection of disease.
e-Consent	Electronic consent system used to print forms to obtain consent from patients.
E-Rostering	A digital software for efficiently scheduling staff shifts, managing leave, and ensuring compliance with organisational policies. It integrates with other HR systems to streamline workforce management.
ECH	Evesham Community Hospital
Endoscopist / Endoscopists	Throughout this text, this expression denotes both medically trained clinicians, as well as non-medical (clinical) endoscopists conducting endoscopic procedures, unless expressly stated otherwise.

ERCP	Endoscopic Retrograde Cholangiopancreatography (these procedures are performed in radiology)
ESR	Electronic Staff Record
EUG	Endoscopy User Group
FIT	Faecal Immunochemistry Test
GI	Gastrointestinal
GRS	Global Rating Scores
Inpatient	This is a patient that is already in an acute hospital bed or someone who requires admission to a bed to enable their procedure to go ahead.
JAG	Joint Advisory Group
JETS	JAG Endoscopy Training System
KTC	Kidderminster Treatment Centre
MCH	Malvern Community Hospital
Medilogik EMS	Endoscopy management system (Electronic endoscopy reporting system – used to maintain endoscopy waiting lists, populate list templates, record and generate procedure reports and audit outcomes against national benchmarks)
NMC	Nursing & Midwifery Council
PDR	Personal Development Review
PEAT	Patient Environmental Action Team. Quarterly inspection to check that infection control, housekeeping and estates are in order.
RTT	Referral to Treatment time
SCSD	Specialised Clinical Services Division
Therapeutic	Treatment which is conducted via the endoscope.
WRH	Worcester Royal Hospital

4. Responsibilities and Duties

4.1. Endoscopy Booking Co-coordinators/Receptionist/Secretaries

All Endoscopy Booking Co-coordinators/Receptionists are responsible for adhering to this policy and the incorporated Countywide Endoscopy Booking Policy WAHT-GAS-007 (see Appendices).

4.2. Endoscopy Nursing Staff

All Endoscopy nursing staff are responsible for adhering to this policy.

4.3. Clinical Endoscopists

All Clinical Endoscopists are responsible for adhering to this policy.

4.4. Clinical Director for Endoscopy

Overall responsibility for this Operational Policy.

4.5. Directorate Management Team for Endoscopy

Overall responsibility for the non-clinical aspects of this Operational Policy and the Countywide Endoscopy Booking Policy (WAHT-GAS-007) (see Appendices).

4.6. Endoscopy Service Support Manager/Endoscopy Support Officers/Admin Team Leaders

Are responsible for ensuring administrative staff adhere to this policy.

4.7. **Operational Policy Author** Ensures This policy is in date and updated as required.

4.8. Hospital staff linked with Endoscopy.

Endoscopy staff are responsible for ensuring the adherence to this policy.

4.9 All Staff

Failure to comply with this policy must be reported to the line manager and, where it is appropriate, report this using the incident reporting system (DATIX).

5. Policy Detail

5.1. Policy Statement

- The Endoscopy service at Worcestershire Acute Hospitals NHS Trust is provided across five hospital sites. These include Worcestershire Royal Hospital, Alexandra Hospital, Kidderminster Treatment Centre, Evesham Community Hospital and Malvern Community Hospital. The service provides care to adult NHS elective, emergency, and cancer pathway patients, as well as occasional private patients.

- Paediatric patients are treated at WRH only, as this is the only site with paediatric services.

- A range of endoscopic procedures are offered across the county. The majority of patients will be outpatients and procedures are usually undertaken within normal working hours. An out of hours GI bleed service is available for emergencies.

- The Trust provides training for both nursing and medical staff, in accordance with JAG, JETS and JETS Workforce standards.

5.2 Site Information –

There are five main endoscopy units within the Trust, and a total of 12 procedure rooms countywide these are:

ECH -1 room – diagnostic service

AGH -2 rooms – diagnostic and therapeutic services and some acute bleed services.

WRH – 3 rooms – Therapeutic and Acute bleed service with on call gastroenterologist. This site houses the main acute specialised services such as ERCP and EUS

KTC 5 rooms – Diagnostic and some therapeutic services.

Malvern – 1 room, is utilised by the Trust to provide Bowel cancer screening, although this is also conducted at KTC and AGH sites.

5.3 Leadership and Organisation

- Endoscopy services are part of the Specialised Clinical Services Division (SCSD) (refer to Appendices for the Endoscopy Organisational Structure). The Division encompasses a wide variety of clinical services - from Outpatients and ambulatory activity to some of the most complex patients on our premises in Critical Care.
- The management team is comprised of the following: Directorate Manager, Matron, Consultant Clinical Director, and Directorate Support Manager who is also the waiting list/PTL manager.
- The service is supported by band 7 JAG/Governance Practitioner who is

responsible for steering quality governance, quality assurance and quality improvement within the service.

- The service also has a band 7 decontamination lead.
- Each endoscopy department unit is managed by a Band 7 nurse and supported by at least one Band 6 sister/charge nurse.
- The endoscopy leadership team are responsible for the service and report directly to SCSD for both clinical governance and performance.

5.4. Endoscopy Operational Directorate Meetings:

- There is a leadership team comprising of clinical, nursing, and managerial lead roles, each with defined responsibilities, there is a defined governance structure for the endoscopy service with clear lines of accountability.
- The leadership team has the managerial, administrative, and technical support to organise and deliver the service effectively.
- Endoscopy Directorate Business meetings and Governance meetings are held monthly. These meetings run separately but are held consecutively. The team works to an agenda to discuss endoscopy-specific items. Minutes are taken at all meetings and are made available to all staff. Any agenda items are sent to the Endoscopy Directorate Manager Secretary. These meetings serve as a platform for the following discussions (this list is not exhaustive):
    - Serve as a forum supporting planning and delivery of an efficient, patient-centred, and cost-effective endoscopy service.
    - Address waiting list management issues, including addressing any identified systemic factors that risk breaches of expected waiting times.
    - Serve to promote safety within the service, including by discussing compliance with established clinical standards, national, regional, as well as internal policies, discussing any emergent safety concerns, incidents, audit results, etc.
    - Aid in workforce management.
    - Aid in finance and resource planning to provide the endoscopy service with adequate support.
- Endoscopy Users Group (EUG) meetings are held quarterly. All users of the endoscopy service are invited to EUG, including representation from urology and respiratory medicine. Clinical audits are presented and discussed at this meeting and any key learning shared within the service. The EUG ensures that there is a clear communication structure throughout the Endoscopy Service and to share and agree improvement ideas and processes, supporting the organisation with the delivery of the countywide Endoscopy service strategy. The group will provide assurance that governance standards within the Trust are adhered to, along with providing evidence that all JAG GRS requirements are achieved and maintained.
- Nursing and booking management teams hold regular, weekly forward-look meetings, where staffing needs, and pre-assessment, as well as procedure list schedules are discussed for the week ahead. These meetings serve as a platform to ensure adequate skill-mix is available to run the endoscopy service smoothly and efficiently.
- Individual endoscopy units hold regular (usually monthly) staff meetings, as well as daily team huddles (see section 5.9.1), focusing on promoting safety, shared learning, as well as fostering constructive staff engagement.

5.5 Access and booking

- The endoscopy service has a dedicated booking team responsible for booking endoscopy procedures. They are supported by the Booking Team Leaders and

supervised by the Directorate Support Manager.

- Referrals are added to the waiting list within one working day of receipt. The waiting list is managed by mutual handover of data between the Medilogik Endoscopy Management System (EMS) and Allscripts PAS (which serves as the central patient data processing software/hub within the Trust IT ecosystem). PTL then draws data from the waiting list contained in Allscripts PAS automatically, and updates within 24 hours of data being recorded in the waiting list in PAS. PTL itself is then managed via the native WREN (Worcestershire Reporting Network) reporting software. The waiting list and PTL validation is undertaken on a weekly basis by the Directorate Support Manager.
- New patient referrals are accepted & managed independent of the route into the service. They are prioritised according to clinical need using agreed priority options. They are vetted by clinical endoscopists for appropriateness if required (see section 5.12 of this Policy for details). Self-referrals are not accepted.
- Booking of all patients is performed in person-centred fashion, where patients have an informed choice of when and where to attend for their procedure. This includes having an opportunity to agree a date and time of their procedure, as well as choice of preferred clinical site, where possible, however complex procedures are only performed on acute sites (WRH or AGH). Reasonable notice and choice are offered to the patient.
- Diagnostic procedures are pooled across all endoscopists who undertake that procedure. Consultants reserve the right to choose to endoscope named patients on their lists, where there is a particular clinical need (e.g. pre-operative assessment of a lesion). Patients requiring advanced therapeutic procedures may be nominated to specific consultant lists who undertake these procedures.
- The endoscopy unit will aim to meet the social, disability and cultural needs of patients accessing the service, and these are recorded as a part of the nursing assessment.
- The unit will monitor the demographic and/or language profile of the population served. The Trust has provisions for interpreting services (see Trust policy for Access and delivery of interpreting services WAHT-CG-682). Whilst we encourage family involvement in patient care with the patient's consent, the use of family to function as interpreter is discouraged.
- Details of booking and scheduling rules, as well as the booking and scheduling process itself are outlined in the Countywide Endoscopy Booking Policy (WAHT-GAS-007), which can be found in the Appendices and forms an integral part of this Endoscopy Operational Policy.

5.6 Productivity, Planning and List Scheduling

- The endoscopy waiting list coordinator/directorate support manager will be responsible for the waiting list/PTL management. They ensure regular administrative validation of waiting lists/PTL. Waiting list information is communicated to the endoscopy team at least monthly and will further be discussed in the Endoscopy User Group meetings and Directorate Business meetings.
- The endoscopy nursing team and clinicians ensure capacity is flexed according to demand. The aim is to ensure waits for recall (surveillance) procedures are < 6 weeks beyond the planned date and that waits are <2 weeks for urgent procedures and <6 weeks for routine procedures, in line with JAG standards.
- 'Did Not Attend' (DNA) and cancellation rates are monitored monthly. Action is taken when required to prevent the DNA rate exceeding 5%.
- The Endoscopy service utilises a robust process for determining and monitoring the capacity of each endoscopy list, as well as standardised scheduling rules for all Endoscopists. This approach helps ensure the efficient and effective utilisation of

resources.

- Each endoscopist's competence is recorded in the Medilogik EMS scheduling software, along with the type of endoscopic modalities they are trained and authorized to perform. Training lists are allocated as 8 points, while non-training lists are allocated either 10 or 12 points, depending on endoscopist experience. The majority of trained Endoscopists are scheduled to perform 12-point lists, unless they have been specifically identified as unable to scope to this standard for any reason, in which case their point allocation is reduced.
- The service follows national guidance for determining the appropriate point values for diagnostic versus therapeutic endoscopy sessions. Senior members of the booking team use this information to build scheduling templates in the Medilogik EMS system, ensuring that each list is optimised for the skill level and capacity of the assigned endoscopist.

5.7 Admission (on the day of procedure)

- Patients are given an allotted arrival time. This may not be their procedure time (refer to the Booking policy WAHT-GAS 007 in the Appendices for further details).
- All patients must be admitted by a registered member of the nursing team in a private room.
- The nurse must keep an accurate record in the Endoscopy Health Questionnaire - PF WR5728 and the Endoscopy Integrated Care document - PF WR5226.
- Relatives usually cannot accompany the patient into the clinical area. The presence of relatives in clinical areas is not permitted unless the clinical team determines that it is in the patients' best interest to do so (e.g. if the patient is a vulnerable adult or a child). This should be recorded in patient notes.
- Patients requiring enema on arrival will be cared for in an area with dedicated toilet with washing facilities.
- Following the admission assessment, patients take a seat in the waiting room or go through to the second stage admission, where they can change in a private area.
- All patients will be cared for with respect and dignity and in single sex accommodation.

5.8 Paediatric Pathway (WRH only)

- Paediatric patients under 16 years of age should be admitted either to the children's ward (Riverbank) or to the Paediatric Day Case Unit, based on bed availability, prior to arrival to endoscopy, accompanied by a dedicated paediatric nurse. All preparation for the booked procedure will be completed prior to the patient being transferred to the endoscopy unit. The patient is accompanied by parents and a paediatric nurse to attend the Endoscopy Unit for the procedure. Paediatric nurses stay with the patient prior to and during the procedure. Patients are then recovered in the paediatric ward. Paediatric patients are seen at the start of the list. Consultants are advised of paediatric patients prior to lists taking place. Young adults, between the ages 16–18, are able to choose if they wish to be admitted directly to the endoscopy unit or via the Paediatric ward. They can be unaccompanied if they prefer and can be seen on any site providing the endoscopist is able to independently prescribe. Young adults cannot be booked on any training lists.
    - Referral received in the Endoscopy Booking Office for children.
    - The endoscopy booking office identifies a suitable appointment slot with an appropriate endoscopist.
    - Children are booked first on the morning list at 8:30am (if this for any reason is not possible, the endoscopy nurses liaise with the paediatric nurse to agree a suitable time and the patient is taken to and from the procedure room).
    - The endoscopy booking office notifies paediatric services of the endoscopy

appointment date and time and checks what bed availability there is to accept the patient on the day of procedure.

- On the day of the procedure, the patient is admitted to the paediatric services.
- The patient is admitted by a dedicated Paediatric Nurse; the nurse assesses the patient and completes admission paperwork. If any further prep is required or a cannula is required, this is completed by the nurse. Children can opt to have a topical anaesthetic prior to having cannula inserted.
- Should the patient or patient's parents have any worries or concerns, they can be discussed with the play specialist or paediatric nurse.
- The endoscopy staff collect the patient from paediatric services and takes the patient to the Endoscopy Department. The dedicated paediatric nurse remains with the patient at all times. The nurse is present throughout the procedure to provide reassurance and helps with decisions on pain relief/sedation if required.
- If the patient requires the toilet whilst in the Endoscopy unit, they use the appropriate same sex toilet on the main corridor in the Endoscopy Unit.
- Following the procedure, the patient is transferred back to the paediatric services from the procedure room.
- Parents are allowed to remain with their child prior to the procedure and after the procedure.
- The patient remains within paediatric services until recovered and ready for discharge.
- Young adults opting to be admitted direct to an endoscopy unit are managed as per the pathway for adult patients.

5.9 Safety

- All Patients who attend the units will have a named Consultant/Clinical Endoscopist who will perform the procedure, and this clinician is responsible for the supervision of their medical care whilst in the department. The clinician will also ensure that the endoscopy procedure report is completed and sent back to the referring clinician and GP.
- The individual needs of the patient will be assessed by the medical and nursing staff and the appropriate individualised care implemented and evaluated. Every effort will be made to maintain the individual's autonomy, independence and privacy and dignity.
- It is the responsibility of each member of the nursing team, to maintain standards of health and safety within the unit and to ensure a safe environment for staff, patients, their relatives, carers, and any other visitors to the unit.
- It remains the nurse's responsibility to keep their knowledge and skills updated and provide support to other members of the unit team. This includes having an active involvement in teaching programmes and promotion of health.
- WAHT provides training for both nursing and medical staff, in accordance with JAG, JETS Workforce & JETS standards.
- A visible register of all practicing Endoscopists and their competencies is on view within each procedure room.
- The Endoscopy units' aim is to provide a friendly, supportive, relaxed, and safe environment for patients and their families.
- Endoscopy procedures will be conducted by appropriately trained and competent Endoscopists, or – if the patient consents to have their procedure conducted on a training list – by a trainee Endoscopist under supervision of an Endoscopist Trainer. All assisting staff in procedure rooms will have also undertaken appropriate training and will have their competency assessed. All endoscopy units

are always fitted with appropriate specialist equipment to provide the right care at the right time to the patients undergoing endoscopic procedures. There are local policies and protocols for the management of diabetes, anticoagulation and antiplatelet and implantable devices in patients undergoing endoscopy. Adult Antimicrobial Guide for antibiotic prophylaxis.

- The Endoscopy service monitors general Quality and Safety Indicators as identified in the BSG Quality and Safety Indicators for Endoscopy. A review of all the BSG A-C auditable outcome and quality standards will be presented bi-annually at the Endoscopy Users Group meeting (EUG)

5.9.1 NatSSIP (National Safety Standards for Invasive Procedures)

5.9.1.1 NatSSIPs are standards that have been developed to set out the key steps necessary to deliver safe care for patients undergoing invasive procedures.

5.9.1.2 Local Safety Standards for Invasive Procedures (LocSSIPs) are how the Endoscopy unit within WAHT has implemented NatSSIP framework. See appendices

5.9.1.3 For further information please refer to Endoscopy unit Local Safety Standards for Invasive Procedures (locSSIP WAHT-SOP-071) which sets out the key steps and use of a pre- peri- and post-procedure safety checklist.

5.9.1.4 Endoscopy nursing teams and Endoscopists ensure that care is harmonised and that key safety checks are performed using the endoscopy safety (adapted WHO) checklist prior to every procedure.

5.9.1.5 The safety (WHO) checklist is integrated within the nursing documentation. (the endoscopy integrated care document).

5.9.1.6 The endoscopy teams on each site will meet every morning before the start of their daily lists. This is known as team huddle/team brief and serves to identify performance or staffing issues, as well as priorities for the day. The team huddle also serves as a platform to communicate any list changes, infection control or equipment issues, as well as shared learning and examples of good practice. The main overall goal is to foster an environment of open communication where important information within the team flows freely, and where endoscopy procedure safety is at the heart of every action.

5.9.2 Audits/Adverse Events

5.9.2.1 In line with JAG standards, the endoscopy directorate monitors, audits, reports on, and acts on a number of BSG key quality indicators.

5.9.2.2 All endoscopy patient safety incidents where patients may have come to harm (including adverse events and near misses) are reported on the DATIX incident reporting system and sent to an investigator to action in line with the overarching WAHT Incident Reporting Policy. Reportable incidents include (this list is not exhaustive): all incidents resulting in death or harm (including perforation), sedation-related complications (including sustained drop in oxygen saturation levels), hospital admissions or readmissions following endoscopic procedures, withdrawal of consent (where request is not managed appropriately), equipment malfunction or failure during procedure, incomplete or incorrect patient identification, delayed diagnosis or missed findings, medication errors,

infection transmission due to inadequate decontamination or cleaning procedures, biopsy or specimen labelling errors, booking errors resulting in delayed diagnosis or treatment, etc. Audits and adverse events are presented at Endoscopy Governance meetings and at EUG.

5.9.2.3 The Clinical Director for endoscopy and/or the Endoscopy Governance Nurse, with the support of the Divisional Governance team, should select those that need a root cause analysis (based on their nature, severity, and frequency) and who should undertake this. The analysis should determine any lessons learnt, which are then documented at meetings with action plans and shared with staff in team huddles.

5.9.2.4 Minutes and agreed actions are circulated to Directorate teams.

5.9.2.5 Any audits that identify performance below acceptable standards, or whose complication rate is significantly higher than his/her peer group, are managed by the Clinical Director for endoscopy.

5.9.2.6 The investigation outcomes need to be conveyed to relevant management to facilitate action e.g. staffing. There is also a duty of candour to the patient to inform them in a timely manner that a patient safety incident has been recorded and that an assessment has taken place.

5.9.3 Thirty-day Mortality and Re-admission audit

- All death or readmission of patients who have had an endoscopy procedure within the preceding thirty days will be reviewed by Endoscopy Clinical Director and Endoscopy Governance Lead.
- These will be monitored monthly, and discussed at Endoscopy Directorate, Governance and EUG meetings.
- If the death or readmission is due to the endoscopy procedure, a DATIX will be completed and reviewed by the Divisional Governance team who will advise if a serious incident (SI) investigation is required.
- Actions and learning will be cascaded to all staff. Where required, the Trust policy on management of performance will be followed.
- Mortality and re-admission report will be submitted to the Divisional Governance monthly to be escalated to Trust mortality group.

5.9.4 Oral Bowel Preparation Risk

- Mechanical bowel preparation can precipitate bowel obstruction in patients with stricturing lesions. This is a rare complication but needs to be recognised.
- If a patient had taken full bowel preparation and has not had any bowel movements, the assessing Endoscopist should arrange for the patient to be seen in A&E or referred to the surgical team and an abdominal x-ray requested. Examination findings, actions taken by the Endoscopist, and nursing interventions should be documented. An incident form should be completed using DATIX.
- WAHT Endoscopy service complies with https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=101157
- The Endoscopy service uses Plenvu as a first line bowel cleansing agent and this policy recognises its authorisation for use in colonoscopy procedures for cleansing the bowel to ensure the bowel is free of solid contents. Other bowel preparation agents such as Picolax, Citrafleet, Citramag, and Moviprep are also in use if the endoscopist states on the referral form.
- The colonoscopy referral form and endoscopy report had been authorised by Drugs and Therapeutic committee as a prescription for bowel preparation. Alternatively, registered professionals can supply bowel preparation under a patient group

direction (PGD). The registered professional must comply with the requirements of the PGD.

- All patients requiring bowel preparation solution in WAHT endoscopy services will be clinically assessed - especially vulnerable patients - by the clinician ordering the endoscopy procedure (including GPs using the direct access route) to ensure that there is no contra-indication or special precaution for the use of a bowel cleansing solution. The colonoscopy referral form includes bowel preparation assessment questions. Furthermore, assessment is conducted by 2WW triage nurses and at nurse-led pre-assessment, usually by telephone, but occasionally face to face. If bowel preparation solution is being dispensed under PGD, the dispensing registered professional must assess whether the patient fits any relevant inclusion or exclusion criteria.
- All patients will have their bowel preparation authorised by the clinician at the same time as the endoscopy procedure is ordered.
- All patients requiring bowel preparation solution in WAHT endoscopy services will have an authorised clinical professional supply the bowel cleansing solution and have written information sent regarding their procedure and bowel preparation.
- All patients requiring bowel preparation solution in WAHT endoscopy services will be supplied with department contact information, should they require advice of a clinical professional.
- Bowel preparation will be stored and supplied in compliance with medicines regulations.
- The Endoscopy service will evaluate the effectiveness and safety of bowel preparation by auditing patient feedback, bowel cleanliness, and by performing regular review of incidents relating to bowel preparation.

5.9.5. Handling of specimens

- Please refer to policy WAHT-SOP-071. Local Safety Standards for Invasive Procedures (locSSIP)

5.9.6 Acromegaly, adrenal insufficient and diabetes insipidus patients

- There is a trust wide Endocrine Policy that has a section for Endoscopy patients pre, intra and post procedure at risk of adrenal crisis. WAHT-END-017 Guideline for the Management of Adrenal Insufficiency in Adults.

5.9.7 Covid-19

5.9.7.1 The COVID-19 pandemic is a novel coronavirus SARS-like respiratory infection that has spread rapidly around the world since first being described in the Wuhan province of China in December 2019. The coronavirus is spread through droplets, with airway and nasopharyngeal secretions being the main source of these.

5.9.7.2 For all known cases of Covid 19 positive patients' staff should wear personal protective equipment in line with local or national recommendations in place at the time a procedure is undertaken. As a minimum, this should include a fluid-resistant face mask in addition to a plastic apron and gloves. FFP3 mask will be made available to staff if required.

5.9.8 Post Colonoscopy Colorectal Cancer (PCCRC) and Post Endoscopy Upper Gastrointestinal Cancer (PEUGIC)

PCCRCs and PEUGICs are defined as a diagnosis of cancer within 4 years after a previous procedure (OGD or colonoscopy) where cancer was not detected (JAG accreditation program - Guide to meeting the quality and safety standards, 2019).

The national audits for PCCRCs and PEUGICs are identified following linkage of HES, bowel cancer screening, and cancer registry datasets. Cases are identified on a trust basis. Each trust nominates a clinical lead for these audits and in WAHT there are two nominated leads for both. Patients with potential PCCRCs or PEUGICs are identified by the national team where the index colonoscopy or OGD was carried out within the trust. Eligible cases are manually reviewed to determinate if there were any endoscopic, patient, or administrative factors associated with the PCCRC or the PEUGIC. The case summaries and findings are then presented at a multidisciplinary meeting (consultant gastroenterologists, consultant colorectal endoscopists, clinical endoscopists and operational leads) to discuss the findings and agree actions required (such as Duty of Candour) as appropriate.

As of late 2024, the funding for the national PPCRC audit has been withdrawn and this audit is closing. As a Trust we will continue to monitor for PCCRC through the colorectal cancer MDT, with identified cases being logged on DATIX. Where a potential PCCRC is diagnosed by another organisation, where we are notified of this, the event will be logged on DATIX.

5.10. Comfort

- The endoscopy unit acknowledges that procedures undertaken can be uncomfortable and undignified and therefore the service is able to offer a full range of sedation techniques to maximise comfort, minimise patient anxiety and perform highly technical endoscopy.
- The endoscopy directorate ensures that patients receive information ahead of time which provides a description of the level of discomfort to be expected during the procedure.
- Patient comfort levels are monitored during all endoscopy procedures, irrespective of sedation levels. Patient feedback collected includes feedback on comfort.
- Nursing teams record comfort levels in the nursing record, as well as actions taken to promote it. An audit of nursing documentation is conducted bi-annually.
- Individual Endoscopists' patient comfort scores are monitored as part of our audit process bi-annually and if these fall below agreed levels, the Endoscopist is required to take remedial action, and scores are reviewed again within 6 months.

5.11 Quality

- The Endoscopist must follow current evidence-based practice and national guidelines in the management of patient undergoing endoscopy procedures.
- This policy does not override the individual responsibility of health professionals to make appropriate decisions according to the circumstances of the individual patient in consultation with the patient and/or carer. Health care professionals must be prepared to justify any deviation from this guidance.
- WAHT endoscopy units will actively monitor BSG auditable outcomes and quality standards for Endoscopists.
- Individual Endoscopists are given feedback on their performance including late outcomes (30-day mortality and unplanned admissions) at least once per year.
- If sub optimal performance by an Endoscopist is noted, actions are taken in response and if an Endoscopists performance does not reach acceptable levels after an agreed development period, the Endoscopy Clinical Director and Directorate governance committee reviews that individual's endoscopy practicing rights.

5.11.1 JAG Annual Timetable

- To continuously achieve JAG standards an annual timetable is held with the Endoscopy JAG/Governance Sister and Endoscopy Directorate General Management.
- This timetable identifies when audits/surveys need to be undertaken. Clinical audits will be presented at the Endoscopy Users Group (EUG) meetings.

5.11.2 BSG auditable outcomes and quality standards for endoscopy.

A review of all the BSG A-C auditable outcome and quality standards will be presented to the Endoscopy Directorate meeting and the Endoscopy User Group meeting.

The Endoscopy Clinical Director and Endoscopy JAG/Governance Sister have the ultimate responsibility to ensure all Quality and Safety Indicators are monitored. This has been delegated to different teams as identified below:

- 24hr emergency GI bleeding service: patients admitted with acute GI bleeding will be admitted via emergency assessment unit and will be resuscitated using the agreed guidance on the emergency care medical assessment document. The Endoscopist will have access to a surgical opinion should this be required. There is provision to perform procedures under general anaesthetic in an operating theatre should this be required. The Endoscopy Directorate will nominate a lead to audit the quality indicators as identified in the BSG Quality and Safety Indicators.

- Therapeutic GI Endoscopy: This includes oesophageal and colonic stenting and dilatation. There are provisions to undertake these procedures in the radiology department under fluoroscopic screening where there is difficulty in passing a guidewire /balloon catheter through the stricture. The Endoscopist has access to surgical and radiological opinions and management should this be required pre or post dilatation. A decision to deploy an oesophageal stent should be agreed at the Upper GI cancer multidisciplinary meeting. The Endoscopy Directorate will nominate a lead to audit the quality indicators as identified in the BSG Quality and Safety Indicators.

- PEG/NJ insertion: Patients requiring PEG placement are discussed and agreed to by the Trusts' Nutrition team. Consent and post procedure care are provided by the Nutrition team as per agreed guidelines. The Nutrition team is responsible for monitoring the quality standards required following PEG insertion as identified in the BSG Quality and Safety Indicators.

- ERCP procedures: The ERCP Endoscopists are responsible for monitoring the quality standards and auditable outcomes required following ERCP as identified in the BSG Quality and Safety Indicators.

- Bowel Cancer Screening Programme (BCSP): The BCSP Team are responsible for monitoring the quality standards and auditable outcomes required for BCSP colonoscopy as identified in the BSG Quality and Safety Indicators.

- EUS OGD & HPB: EUS Endoscopists are responsible for monitoring the quality standards and auditable outcomes required or may delegate to appropriate person.

- Cystoscopy: The urology team are responsible for monitoring the quality standards and auditable outcomes required or may delegate to appropriate person.

- Bronchoscopy & EBUS: The Respiratory team are responsible for monitoring the quality standards and auditable outcomes required or may delegate to appropriate

person.

5.12. Appropriateness and referral rules

- Referrals are accepted and managed in the same way, independent of the route into the service.
- All referrals undergo administrative pre-checks (i.e. clerical vetting) by the booking coordinators for legibility, whether bowel preparation is prescribed for lower GI endoscopy requests (in the case of new referrals, there is a need for the patient to be clinically vetted for fitness to take bowel prep). All surveillance procedures can have bowel prep dispensed via a PGD for the relevant preparation of choice. Plenvu is the default mechanical bowel preparation. That the referral form is signed by the referring clinician. Referrals need to be submitted in electronic format, with the only existing exception of urgent and emergency inpatient referrals, which can be accepted in paper format. All referrals, without exception, need to be submitted on a correct referral form.
- Any inaccuracies will be escalated to the referring clinician. An audit of the clerical vetting process will be conducted by the Directorate Support Manager once a year.
- All patients should be referred against specific NICE, BSG or other relevant clinical guidelines using the approved referral form. Referrals to Endoscopy need to comply with the Endoscopy Referral Guidelines (WAHT-GAS-003, see Appendices). This policy is also available on the Trust intranet. An audit of compliance against referral guidelines should be undertaken annually.
- Audit results are discussed at Endoscopy Directorate, Governance, and EUG meetings.
- Referrals from non-Endoscopist are clinically vetted for appropriateness by an Endoscopist. Once vetted, the patient is added to the waiting list RTT starts from date on referral.
- The vetting process is guided by the Countywide Process of Vetting of Endoscopy Referrals to WAHT Units (WAHT-GAS-015 – see the Appendices). This is to ensure patients follow the correct pathway and guidelines and receive their endoscopy in a safe and timely manner. The process aims to ensure that patients are referred and booked appropriately. This applies to new referrals, as well as surveillance procedures.

5.12.1 Endoscopy Booking Policy

- For booking of endoscopic procedures please refer to the Countywide Endoscopy Booking Policy (WAHT-GAS-007) (see Appendices) for referral, scheduling and booking rules, including escalation processes.
- There is a range of communication methods and materials to ensure that patients are appropriately informed about what they should expect from the service.
- Patients are routinely sent written information regarding their procedure prior to their appointment and provided with contact details to seek further information, clarification, or help.

5.12.2 Pre-Assessment

- Pre-assessment in endoscopy is crucial for ensuring patient safety and optimising service efficiency. By evaluating patients prior to the procedure, healthcare providers can identify potential risks, such as contraindications or the need for special preparations, thereby reducing the likelihood of complications. Additionally, pre-assessment streamlines the process, enabling more effective scheduling and resource allocation, which enhances overall service effectiveness and improves patient outcomes. This proactive approach ensures that both the clinical and

operational aspects of endoscopy are managed efficiently, leading to better care and patient satisfaction.

- Pre-assessment for procedures requiring oral bowel preparation is available either face-to-face, by telephone or, where appropriate, by review of medical records prior to postal supply of bowel preparation. Telephone or face-to-face pre-assessment is expected to be the norm and postal pre-assessment should only be used exceptionally.
- ERCP's and high-risk procedures are not currently pre-assessed on a regular basis, however, there is a policy in draft form that once approved will be used to safely complete pre-assessment for ERCP (**Management of patients undergoing ERCP (Endoscopic, Retrograde, Cholangio Pancreatography) at WRH – Draft V1) Yet to be approved**
- Other patients are scheduled for pre-assessment based on procedural needs (e.g. If they are planning to undergo endoscopy with general anaesthesia).
- All appropriate patients will be given an appointment to be pre-assessed by a trained member of the nursing team. The nurse will then discuss the procedure, sedation, bowel preparation and (if required) any changes or modification to the patient's current medication regimen.
- Pre-assessment is undertaken to alleviate any worry about taking bowel preparation, reduce on the day waiting times, DNA rates, and enhance procedural, as well as bowel preparation safety. Dedicated time is given to reassure patients and allow them time to ask any questions regarding bowel preparation or the procedure they are booked to have.
- Formal pre-assessment policy is being actively developed and will form an integral part of this Endoscopy Operational Policy once it is agreed and published. It will then be accessible via the Endoscopy section of the Key Docs document server on Trust Intranet.

5.12.3 Off-unit and emergency endoscopy

- Off-unit endoscopic procedures should only be performed when necessary and when they cannot be safely conducted within the endoscopy unit.
- Endoscopists must adhere to standard operating procedures for the specific off-unit setting and liaise with relevant departments to co-ordinate off-unit procedures.
- Adequate communication and coordination between all involved departments and personnel are essential to ensure a smooth and efficient procedure.
- Emergency patients scoped in theatres (e.g. with catastrophic GI bleeding) should be booked as CEPOD cases, and discussed with the theatre nurse coordinator, as well as the on-call anaesthetist prior to the patient or any equipment being brought into theatre. Those patients who are reasonably stable and do not require anaesthetic support should be scoped in the endoscopy department with the endoscopy nursing team recovering the patient. Those patients being scoped as a CEPOD case will be recovered by the theatre recovery team.
- A pre-procedure discussion with ICU should be had for patients with a Rockall score of 4 of greater (>25% mortality) as a period of 12-24 hours ICU care post procedure may be appropriate for these patients.
- Emergency equipment and medications must be readily available during off-unit procedures.
- Post-procedure care should be provided in accordance with established protocols, with appropriate documentation of the procedure and any complications encountered.
- The number of off-unit endoscopy procedures is monitored via EMS Medilogik.

5.13 Results

5.13.1. Electronic Reporting and Procedure Results

- All patients undergoing an endoscopic procedure will have a report completed on the day of the procedure using a National Endoscopy Database-compliant endoscopy reporting system. The Trust currently use Medilogik EMS.
- This includes all cases performed outside the endoscopy unit, such as emergency procedures performed in theatres or ITU, or ERCPs and other procedures performed in radiology.
- A copy of the endoscopy report is sent to the patient's GP. A copy is automatically uploaded to CLIP notes. A copy is also sent to the referrer or the Endoscopist responsible for acting upon the results, depending on referral route (see section 5.13.2 for details).
- If histopathology has been taken, results will be communicated to the appropriate clinician via the ICE reporting system. For fast track/ urgent specimens please refer to LP-U-HIS-Urgent Requests in the appendices.
- When digital photographs are taken, they are accessible through electronic patient records or on EMS Medilogik, along with the report. If physical photographs were taken due to image capture failure, they will be kept with the Endoscopy report and scanned into patient notes on the electronic patient record along with the report (in CLIP).
- The requesting clinician / Endoscopist will undertake any actions and make recommendations, where necessary. Histology reports should be actioned by way of patient letter/contact within a 14-day period of the report being published on ICE by the requesting clinician. Histology results are to be filed on the ICE reporting system once actioned. AHT-CG-828
- Please also refer to section 5.27 of this text, which covers the use of agency, insourcing, bank, and locum staff. Additionally, consult the 'Procedure for Management of Patient by Insourcing and Locum Providers' Standard Operating Procedure (WAHT-GAS-010) in the Appendices. These sections provide detailed information on the management of histology and other results of endoscopy procedures when insourcing or locum consultants are responsible for a patient case.
- Patients requiring follow-up procedures are added to the waiting list automatically by the Medilogik EMS endoscopy reporting and scheduling system. However, due to historic issues with capturing data about repeat procedures on the previously used scheduling software, these patients will also have a physical copy of their endoscopy report placed in a dedicated ("red") tray by the endoscopy nursing staff on the day. These report copies are then to be gathered at the end of day or end of session and brought to the booking office by the nursing staff. This is so the booking team can ensure these patients have been added onto the waiting list and no repeats are missed. Red tray/repeat procedures are subject to regular (usually monthly) audit by individual endoscopy units. The endoscopy directorate business meeting and/or governance meeting may take a decision to suspend this "red tray" practice and audits provided this system proves redundant following full EMS Medilogik implementation.

5.13.2 Communicating Results to the Referrer, Rebooking, and Discharges

- The endoscopy nurses return the patient event packs (including paperwork) to the endoscopy booking office once the patient is discharged.
- Paperwork is filed appropriately in the event notes, using the EZ notes event packs.
- As already stated in section 5.13.1 a copy of the report is sent to referrer and GP.
- The endoscopy booking coordinators check the endoscopy report. If a patient requires a repeat procedure, the endoscopy booking coordinator will ensure the

patient has been added to the repeat procedure waiting list.

- If repeat procedure is indicated within 3 months, it should be booked straight away where possible, before the patient leaves the department.
- The endoscopy booking coordinators discharge the patient as per local electronic process.

5.13.3 Process for ongoing management and support of patients with suspected cancer or other significant pathology

- If findings during endoscopy indicate a serious medical condition (such as, but not limited to) suspected cancer, the Endoscopist will document this in the procedure report and inform the patient of the preliminary findings.
- This discussion should occur post-procedure in an appropriate manner and setting. Private rooms are available in endoscopy units specifically for confidential patient discussions of this nature.
- Sufficient time should be allocated for this conversation, with clear, compassionate, and non-technical language used.
- The Endoscopist will explain to the patient the nature of the preliminary findings, their implications, and the next steps in the care pathway. These include:
    - Referral of the case for discussion in a multidisciplinary team (MDT) meeting if this is indicated by the nature of the findings (e.g. suspected cancer). See section 5.18 for details.
    - Referral for further investigations to assess the abnormality found (e.g. further imaging).
    - Expected turnover timeline on any biopsies or other samples if these were taken during the procedure.
- The Endoscopist will also ensure the patient is offered information about available support services. This includes referring the patient to the available dedicated clinical nurse specialist team, where this is appropriate (such as in cases of suspected cancers, in new diagnosis of inflammatory bowel disease, etc.).
- Written information should be provided where possible and appropriate, and contact details for a designated specialist nurse or support staff should be offered for any further questions or concerns.
- All communications with the patient and their family regarding the pathology findings should be documented in the patient's medical record. A detailed report should be sent to the patient's GP and any referring specialists promptly, ensuring all relevant parties are informed and updated on the patient's condition and care plan.
- The endoscopist must ensure that any relevant further investigations and referrals are promptly requested without undue delay. This encompasses ordering additional imaging studies, referring the case to the MDT, and facilitating referrals to relevant specialist nurses or nursing teams. These follow-up actions must be completed within 24 hours of initial preliminary diagnosis.

5.14 Privacy, Respect, Equality, Diversity, Dignity and Security

- Maintaining patients' privacy, dignity, and respect is paramount throughout the

endoscopy experience, ensuring that all patients, regardless of their background, feel equally valued and respected.

- It is the responsibility of all staff to maintain patients' privacy and dignity and to promote security, ensuring that all patients are treated with fairness and without discrimination.
- Clear signage leads patients throughout the hospital to the Endoscopy unit, with consideration given to accessibility and inclusivity for patients with diverse needs, including those with disabilities or other barriers to accessing care.
- Entry into all clinical areas within Endoscopy units is through secured doors to prevent unauthorized access, with additional measures taken to accommodate patients with mobility or sensory impairments.
- Endoscopy units are to be kept clean, organized, and uncluttered at all times, creating an environment that is welcoming, inclusive, and accommodating to patients from diverse backgrounds.
- Efficient patient flow management through Endoscopy ensures a smooth patient journey, with consideration given to the unique needs and preferences of each patient, including those from diverse cultural or religious backgrounds.
- All staff must undertake Equality, Diversity, and Inclusion training in line with the Trust's policies to reinforce the importance of respecting and valuing diversity among patients and colleagues (please refer to Trust's Equality, Diversity, and Inclusion Policy available on Trust intranet).
- Each Endoscopy unit in WAHT will have a nominated dignity champion who actively promotes equality, diversity, and inclusion within the unit.
- Endoscopy units ensure that patient privacy is adequately protected throughout their endoscopy patient journey, with consideration given to cultural or religious preferences regarding modesty and privacy.
- All reasonable care must be taken to protect patient dignity, including through use of appropriate environmental features, such as strictly gender-segregated clinical areas, consistent use of curtains, and other sight-occluding barriers, availability of dignity shorts for patients to change into for lower GI endoscopy procedures etc.
- To ensure a safe, dignified, and welcoming environment, the procedure rooms should only be accessed by staff directly involved in the endoscopy while the patient is present for their procedure. Entry by other staff members is strictly prohibited unless in the case of a genuine emergency.
- Endoscopy units all have access to quiet/private areas for conversations pre and post procedure with patients, with consideration given to the diverse needs of patients, including those who may require additional support. Nursing staff should document in the patient's Endoscopy Integrate Care document if a private room is not available to discuss clinical care.

5.14.1. Providing Inclusive and Respectful Care for All Patients, Including Gender Diverse Individuals

- Worcestershire Acute Hospitals NHS Trust adheres to the national rules on gender separation in clinical areas, while also respecting and accommodating the diverse gender identities of patients. Recovery areas are flexed to provide same-sex

accommodation or alternative arrangements as required by patients (refer to Trust Policy for the Provision of Same-Sex Accommodation for Patients available on Trust intranet).

- Gender segregation is required routinely from admission through to recovery wherever patients are required to undress and/or have received sedation or associated drugs. Where genders cannot be segregated, single sex lists are to be undertaken.
- All justified and non-justified gender segregation breaches are recorded and reported, with reports available for auditing and inspection purposes, and to draw lessons to improve the quality of service.
- Endoscopy units provide respectful and affirming care to transgender patients, including using appropriate name and pronoun preferences, and ensuring privacy and dignity throughout their endoscopy experience.
- Staff are trained to understand the unique healthcare needs and concerns of transgender patients, including those related to hormone therapy, surgical history, and gender-affirming care.

5.14.2. Supporting patients with physical and mental disabilities

- Endoscopy units actively support patients with mental and physical disabilities, ensuring that all facilities and services are accessible and accommodating to their needs.
- Staff are trained to provide appropriate support and assistance to patients with disabilities, including but not limited to mobility aids, communication devices, and sensory support.
- Endoscopy units provide clear communication and information in accessible formats, such as large print, or easy read, to ensure that patients with visual or cognitive impairments can fully understand and participate in their care.
- Reasonable adjustments are made to procedures and protocols to accommodate the individual needs of patients with disabilities, ensuring that they receive the same high standard of care as any other patient.
- Patients with disabilities are offered additional support and assistance throughout their endoscopy experience.
- Staff are trained in disability awareness and sensitivity, ensuring that they have the knowledge and skills to interact respectfully and effectively with patients with disabilities, including understanding their rights under the Equality Act 2010.
- Feedback from patients with disabilities is actively sought and used to inform service improvements and developments, ensuring that endoscopy units continue to meet the diverse needs of all patients, regardless of disability status.

5.14.3. Supporting patients to overcome language and communication barriers in accessing Endoscopy services.

- Endoscopy units recognise the importance of effective communication with patients who have language barriers, ensuring that all patients receive clear and accurate

information about their care and treatment.

- Trained interpreters, including face-to-face, phone, and video interpreters, are available to assist patients with limited English proficiency, ensuring that language barriers do not impede access to quality care. This also includes availability of interpreters in British sign language.
- Family, friends, or carers are not relied upon for interpreting services, as this may compromise patient confidentiality and accuracy of communication. Instead, trained interpreters from outside interpreter services are utilised to maintain professionalism and accuracy. However, if using friends or family as interpreters is expressly the patient's choice, this will be respected. Nevertheless, this choice needs to be confirmed using an appropriate interpreter (usually by means of phone or video interpreting) and documented in patient notes.
- Endoscopy units ensure that interpreters are available and accessible to patients throughout their endoscopy experience, including during pre-procedure consultations, informed consent discussions, and post-procedure care.
- Staff are trained to effectively collaborate with interpreters, ensuring that they understand their role in facilitating communication and respecting patient confidentiality.
- In cases where novel modalities such as video interpreting are used, consideration is given to practical limitations during procedures, especially if patients are sedated. Alternative communication methods may be employed to ensure patient safety and understanding Click on this link to view Interpreting and Translation (sharepoint.com)

5.14.4. Safeguarding and care for vulnerable patients

- All staff must follow the Trust safeguarding policy for adults and children.
- All Trust staff receive and maintain competence in mandatory safeguarding adult and child training. This is monitored throughout the Electronic Staff Record.
- The Trust Safeguarding Policy for both Adults and Children (see Appendices) provides clear guidance and procedures for safeguarding vulnerable adults and children within the endoscopy unit, including reporting mechanisms, escalation processes, and multidisciplinary collaboration with safeguarding teams and external agencies. Endoscopy staff maintain confidentiality and privacy when safeguarding concerns arise in accordance with the policy.

5.15 Patient information & Consent

- Before an Endoscopy procedure is undertaken all relevant information should be given to the patient. Patients have written information routinely sent regarding their procedure prior to their appointment, as well as information about bowel preparation if this is applicable. Patients are also supplied with department contact information, should they require the advice of a clinical professional.
- Copies of patient information leaflets are available on the Trust Key Docs Document server, as well as the e-Consent consent form generating computer system.
- All published patient information leaflets are reviewed annually and updated, as necessary. These are sent for review by the Key Documents Team and assigned a documents reference number prior to publication.
- All endoscopy sites use e-Consent forms, where appropriate. The e-Consent is printed at the time of booking and sent to the patient together with procedure information in advance of their admission.

- Patients should be given an opportunity to ask questions prior to their procedure. This should be done by both the Endoscopists and members of the nursing team.
- Prior to any endoscopy procedure taking place, all patients must sign a consent form before entering the procedure room. Obtaining consent solely in the procedure room is considered a clinical incident, reportable via the DATIX incident reporting system.
- Each patient should be made aware of the risks and benefits of the endoscopic procedure and should receive both written and verbal instruction surrounding consent.
- The trained professional obtaining patient consent has a duty to ensure that the patient is aware of any material risks involved in any recommended treatment and that any reasonable alternative variant treatments should be discussed.
- All patients are given sufficient time to ask questions before consent is agreed and before entering the procedure room on the day. Communication and relating to individuals whilst accounting for equity and diversity is key to consent. Each participant should be treated as an individual, some will need additional time and resources, allowing the participant to access information in a format which is accessible to them.
- Diversity includes communicating with patients in a way that they can understand and at a level that they can understand. Interpreters, learning disability nurses and sign language specialists all have a role to play within the consent process.
- Applicable consent processes and guidelines must be followed at all times. For all planned procedures we follow two-stage consent - the patient information and copy of the consent form are sent out to the patient. The nurse's role within the consent process is to confirm consent when the patient arrives.
- Valid consent can only be gained when participants have the capacity to make informed decisions about their treatment. Where lack of capacity is suspected, patients will require a full assessment under the Mental Capacity Act. In such cases, Part 1 of a Consent Form 4 will need to be completed by the referring clinician prior to the patient being admitted to the Endoscopy Unit to ensure any proposed procedures are carried out in the best interest of such patient.
- Individual endoscopy units conduct annual audits of the consenting process as part of the annual Patient Experience Survey.

5.15.1 Withdrawal of consent.

- Before the procedure begins, the patient should have the opportunity to discuss whether they wish to continue with their consent or withdraw it, following consent guidelines. This can be done by either a nurse or the Endoscopist during the consent-confirming step in the WHO checklist pre-procedure SIGN-IN. If during the procedure the patient withdraws consent, it is the nurse's responsibility to speak up and advocate for the patient once it has been clearly determined that consent has been withdrawn. If the endoscopist insists on continuing the procedure after consent has been withdrawn, then this should be recorded on Datix.

5.15.2 Consent for high-risk procedures and high-risk patients.

- **High-risk patients** are defined as all patients with ASA score of 3 or greater as defined by the ASA classification.

  High-risk procedures are defined as therapeutic OGD, PEG/PEJ insertion, ERCP, EUS/EBUS-guided sampling (or EUS/EBUS guided interventional therapy) and EMR.

- Clinicians referring high-risk patients or any patients for high-risk procedures should clearly identify additional risk factors on the referral form or on the endoscopy report serving in lieu of a referral.
- Two-stage consent should be performed for all high-risk patients and for patients scheduled for high-risk procedures.

In-Patient Procedures:

- A consultant-to-consultant referral is recommended.
- On receipt of an inpatient referral, the nursing team will perform clerical vetting (analogous to the process of administrative pre-checks undertaken by booking coordinators for outpatient referrals as outlined in section 5.12 of this Policy). An Endoscopist will then perform clinical vetting for appropriateness. This process is guided by the Countywide Process of Vetting of Endoscopy Referrals. If the procedure is deemed appropriate, nursing teams must print off procedure information and e-consent form, accessible either via CLIP or e-Consent applications. In addition, they must print the Inpatient Endoscopy Procedure Safety Checklist.
- These documents must be given to the referring ward doctor to return to the ward and start the consenting process by providing the patient and carers with all relevant procedural information. Information must include an explanation of the risks of and alternatives to the procedure, and where applicable the risk of bowel preparation. The consent process will continue in the Endoscopy Unit where the Endoscopist will confirm consent.
- The Endoscopy Procedure Safety Checklist serves as a prompt/memory aide to facilitate handover between ward nursing staff and endoscopy nursing staff. It also serves to capture crucial information about the patient necessary to ensure safe inpatient endoscopy. Ward nursing staff should have their part of this document filled-in and ready when endoscopy nursing staff comes to collect the patient for their inpatient procedure.

Elective Procedures:

- If a patient requires a repeat procedure with high-risk intervention or if they are a high-risk patient as above. Nursing teams must print off procedure information, e-consent from either CLIP or e-Consent applications.
- The discharge nurse must provide the patient and carers with all relevant procedural information if appropriately trained to do so. Where applicable, the risk of bowel preparation should be discussed. The Endoscopist on the day must address the patient's questions where nursing teams are unable to answer.
- Patients must be provided with a contact number to reach out to in case they require any further information about their procedure.

5.16 Aftercare

- Non-sedated patients are discharged from the procedure room or recovery area once the Endoscopist or nursing staff has discussed the results and aftercare with the patient.
- Sedated patients are not discharged until diet and fluids have been consumed (if applicable), their cannula has been removed, and a responsible adult is available to collect them from the Endoscopy Unit. It is essential that those who have any procedure with or without intravenous conscious sedation, opiates or Entonox return to normal preadmission consciousness and physical state before discharge. Documentation of recovery observations and events must be completed and signed

prior to discharge. A competent adult will escort the patient home and remain with them for a minimum of 12 hours following the endoscopic procedure.

- All patients are discharged following a conversation with the Endoscopist or nursing staff regarding their procedure. Patients will be informed of procedure outcomes, clinical findings, and next management steps as an integral part of the discharge process. Patients are discharged with verbal and written information. A patient centred discharge summary or the endoscopy report is handed to the patient upon discharge.
- Patients should not be discharged until the endoscopy nursing team has completed all relevant paperwork and provided the patient with discharge information. This information must include emergency contact numbers and follow-up details.
- Any further procedures required are to be discussed with the patient. If these procedures are to occur within the next three months, they should be booked prior to discharge, if possible.
- Any post-procedure risks should also be discussed with the patient before discharge.
- Any patients with suspected malignancy or other suspected significant pathology are informed on the day of procedure unless it is clearly inappropriate to do so. See section 5.13.3 of this policy for further details.
- All aftercare leaflets are available to obtain in multiple languages which we can obtain prior to the procedure if aware or obtain them afterwards and forward them on.
- The referring consultant or endoscopist will write to the patients with the results of relevant clinical findings upon receipt of the laboratory report (e.g. histopathology).
- If patients require emergency treatment following their procedure at the Endoscopy Units at Evesham, Kidderminster or Malvern, patients are transferred via Ambulance to Alexandra Hospital, Redditch or Worcestershire Royal Hospital.
- For further information, please refer to the Clinical Monitoring and Safe Discharge of Patients Attending the Endoscopy Unit Guideline in the Appendices.

5.17 Surveillance Procedures

- All surveillance procedures will be validated/vetted both clerically and clinically according to latest guidance and booked with an appropriately enhanced allocated time/number of points per procedure (refer to the Countywide Endoscopy Booking Policy in the Appendices and to BSG guidelines).
- Patients requiring a surveillance Endoscopy procedure must be informed that they have a surveillance procedure due or that recent guidelines have changed, and their surveillance procedure has been postponed or cancelled.
- Any repeat surveillance referrals must be added to the waiting list at time of decision, to include repeat date.

5.18. MDT Co-Ordination

- Where a suspected or likely cancer is identified, patient cases are linked to an appropriate MDT, managed by Cancer Services. This ensures that each patient receives comprehensive care planning and management, integrating input from various specialists to optimise outcomes.
- Endoscopists refer patients to the MDT coordinator by email when required. Patients with a confirmed diagnosis of cancer, or in cases where cancer is suspected, are systematically reviewed during weekly MDT meetings.

- The Trust histopathology reports include SNOMED codes and these are utilised by the MDT coordinators to identify patients who may not have been notified to the MDT coordinators for inclusion in the MDT discussion. This process provides some safety-netting to patients and allows for timely inclusion of patients found to have a cancer that may not have been evident at the time of the procedure.

5.19 Patient Feedback and Patient Involvement

- Endoscopy units actively involve patients in their care and decision-making processes, ensuring that patients are informed, empowered, and engaged in their healthcare journey.
- Patient feedback mechanisms are in place to gather insights and suggestions for improving the endoscopy experience, including post-procedure surveys, the Friends and Family Test and annual Patient Survey.
- Endoscopy units encourage open and transparent communication with patients, welcoming feedback on all aspects of their care, including communication, facilities, and staff interactions.
- Patient feedback is used to drive continuous improvement initiatives within the Endoscopy service, with a focus on enhancing patient satisfaction, safety, and overall experience.
- Staff are trained to actively listen to patient concerns and suggestions, demonstrating empathy and responsiveness to patient feedback.
- Patient involvement in service planning and development is encouraged, with opportunities for patients to participate in quality improvement projects.
- Patient Survey questionnaires are distributed annually over a two-month period to a representative mix of patients attending individual Endoscopy Units. This process aims to gather comprehensive feedback from a diverse patient population to assess the quality of services provided.
- Patients are asked to provide feedback on these areas:
    - Booking services
    - Invitation Materials
    - Consent
    - Comfort
    - Staff
    - Aftercare process
    - Privacy & Dignity
    - Sedation Options
    - Background
    - Social, disability and cultural needs
- Feedback and Survey results are collated, and comprehensive reports are produced to summarise the findings. These reports provide valuable insights into patient experiences and identify areas for improvement.
- Action plans are developed once the results have been received. These plans are then distributed to the relevant Endoscopy teams to address any identified issues and implement necessary improvements. This ensures a proactive approach to enhancing service quality.
- Results and subsequent action plans are reviewed by the Endoscopy Directorate, Governance, and Endoscopy User Group (EUG) meetings once they are available. This multi-tiered review process ensures that feedback is thoroughly evaluated and

that improvements are systematically implemented across all levels of the service.

- Endoscopy units communicate outcomes and actions resulting from patient feedback, demonstrating a commitment to accountability and responsiveness to patient needs and preferences.

5.20 Environment

- Endoscopy procedure rooms are cleaned at the end of each list. Single use disposable equipment is used throughout the Endoscopy Units.
- Cleaning, Decontamination & Validation of Flexible Endoscopes Policy (WAHT-INF-039) forms an integral part of this Operational Policy and can be found in the Appendices.
- BSG guidelines are followed for decontamination of Endoscopes. Testing and revalidation of all decontamination equipment and associated machinery is carried out according to national decontaminations requirements and local policy (see the Cleaning, Decontamination & Validation of Flexible Endoscopes Policy WAHT-INF-039 in the Appendices).
- An annual authorised engineer (IHEEM) report for decontamination is actioned and approved by the Endoscopy service, along with the annual Environmental checklist.
- Staff must always follow the standard of Trust dress and uniform policy. ID badges should be clearly visible. Protective clothing is provided and should be worn when on the endoscopy units. Endoscopists must wear either appropriate uniforms or theatre blues and appropriate footwear. The 'bare below the elbow' policy is to be adhered to. Lanyards are not permitted.
- To abide by the infection control policy.
- All infection control audits are carried out monthly (e.g. hand hygiene, daily/weekly cleaning and Fridge temperature charts audit).
- All staff abide by the rules set out in the COSHH policy and Cleaning, Decontamination & Validation of Flexible Endoscopes policy when handling, transferring, and storing decontamination fluids.
- Any spillage of Peracetic acid refers to the Trust Peracetic Acid spill Policy. All staff must attend mandatory fire training annually.
- All rooms keep a supply of controlled drugs provided by Pharmacy. These controlled drugs are kept in a double locked cupboard (refer to trust Controlled Drugs Policy). Quarterly pharmacy audits for safe and secure handling and storage are completed and results fed back to each Endoscopy unit with action plans if improvement is necessary.

5.20.1. Equipment

- Endoscopy units all have a range of modern Olympus video endoscopes, with sufficient numbers of endoscopes to cover the booked lists.
- There is a computer in each endoscopy procedure room for immediate access to the electronic endoscopy reporting system, as well as other IT systems and software necessary for efficient endoscopy. Image capture is available in all procedure rooms. As a backup to digital image capture, endoscopy stacks are equipped with photographic printing equipment. There is a dedicated area within each endoscopy unit to house the resuscitation trolley, oxygen, suction and emergency drug box. All resuscitation trolleys must be maintained in a state of

immediate readiness. Trollies will be checked and maintained in accordance with the trust policy.

5.20.2 Decontamination

- The decontamination units across the county aim to provide effective endoscope decontamination service within IHEEM and HTM guidance within a safe environment as required by the Health Act (2006).
- The Endoscopy service is required to provide safe decontamination that generates a clean and highly disinfected product and is embedded as part of the service culture in support of successful clinical outcomes and the associated well-being of patients and staff.
- Routine decontamination of flexible endoscopes will take place in dedicated facilities that are compliant with the latest National guidelines / BSG / IHEEM / GRS standards and guidance and are fit for purpose. Compliance with standards is established through an internal and external audit program. Results of ongoing audits provide evidence of any non-compliance issues that may require funding in order to maintain current JAG registration and certification. All items should be traceable through the various validated decontamination processes and be traceable to individual patients.
- Each Decontamination unit has a team that is trained to disinfect and reprocess Endoscopy. Any personnel allocated to decontamination should have qualifications compliant with NETB24/1.
- Yearly audits are carried out using relevant audit tools. Results are presented at the Endoscopy Directorate meeting and Trust-wide Decontamination committee, with actions arising dealt with in a timely manner.
- Decontamination services will be reviewed by the decontamination group chair and also the Decontamination Lead as described in NETB24/1 for the Trust.
- Further details are expanded on in the Cleaning, Decontamination & Validation of Flexible Endoscopes policy (see Appendices), including management of decontamination of scopes in the event of washer failure on a site.

5.21 Teamwork, Workforce Delivery & Planning for the Future

- All staff are regarded as valuable team members.
- There are named individuals across each site that are responsible for managing the rostering of Endoscopy staff to meet service needs.
- All staff have a work base, but the service may require them to work across sites within the Trust. This also includes the requirement to staff an on-call emergency roster to cover 24 hours a day, 7-day-a-week emergency endoscopy service.
- Skill mix is kept as compliant as practicable with BSG's UK consensus on non-medical staffing required to deliver safe, quality-assured care for adult patients undergoing gastrointestinal endoscopy. Skill mix and staffing needs are regularly reviewed at monthly Directorate meetings, as well as the weekly forward-look meetings of endoscopy and booking management teams, where staffing needs and skill mix are discussed for the week ahead.
- Each endoscopy unit's manager is responsible for overall unit efficiency, supported by their junior staff (sisters and charge nurses).

- The Endoscopy nursing teams use E-Rostering to plan and record staff rotas.
- Staff sickness is recorded on either E-Rostering
- Sickness and absence rates are constantly monitored and audited as per the Sickness Absence, Health, and Well Being Policy See appendices. This is discussed at directorate and divisional level. This is to ensure sufficient competent staff with an appropriate mix of skills are available to allow for rostering of staff to support the service activity. If staff shortfalls are identified, this will be addressed by proactive measures taken by the Management team to ensure sufficient staff are available to provide seamless patient care. This includes but is not limited to providing a budget for sourcing of temporary/agency/bank staff, and regular review of staff numbers/vacancy rates.

5.21.1 Skill Mix

- Skill mix is kept as compliant as practicable with BSG's UK consensus on non-medical staffing, as well as other applicable recommendations and guidelines for endoscopy staffing. It is consistently kept at a level required to deliver safe, quality-assured care for adult patients undergoing endoscopy. Breaches of skill mix compromising this requirement need to be raised as a reportable incident via DATIX, so that action plan could be put in place to mitigate risks of recurrence.
- Skill mix and staffing needs are regularly reviewed at monthly Directorate meetings, as well as the weekly forward-look meetings of endoscopy and booking management teams, where staffing needs and skill mix are discussed for each week ahead. Skill mix and staffing needs are also subject to an overall annual review.
- Clinical Staff will rotate and work in all clinical areas of the unit and similarly clerical staff should be competent in all tasks within the booking office.
- Local policy to ensure safe and quality clinical outcomes for the patient requires the following skill mix:

Area/Procedure	Staffing
Admission	1 Registered Practitioner for 1- 2 rooms or 2 Registered Practitioner for three or more procedure rooms
Recovery	2 Registered Practitioner in each recovery area for two rooms or more and 1 Registered Practitioner for one room
Colonoscopy (Diagnostic)	1 Registered Practitioner 1 Trained HCSW
Colonoscopy (Therapeutic)	2 Registered Practitioner
Gastroscopy (Therapeutic)	2 Registered Practitioner and 1 Trained HCSW / Registered practitioner
ERCP	3 Registered Practitioner plus transfer Registered Practitioner
Bronchoscopy/EBUS	2 Registered Practitioner 1 Trained HCSW / Registered practitioner
Cystoscopy	1 Registered Practitioner and 1 Trained HCSW
Decontamination room	1-2 CSW for 1-2 room and 3 CSW for three or more rooms
Inpatient List	2 Registered Practitioner, 1 Trained HCSW plus transfer Registered Practitioner

5.21.2 Workforce Development, Productivity and Future Demand Planning

- The Endoscopy Service continuously strives to enhance productivity and effectively plan for future service needs. A key aspect of this process is the annual review of skill mix and staffing requirements, conducted as part of the Budget setting for the upcoming financial year each spring. Adjustments are made based on the service's evolving needs, with proposed changes subject to approval by the Nursing Workforce Action Group (NWAG), led by the Trust's Deputy Chief Nurse. This ensures that the service's workforce is appropriately sized and skilled to meet the anticipated future demands in volume and type of procedures.
- The Endoscopy Service also utilizes the in-house developed Pythia software to model capacity and future demand, providing a detailed scheduling and forecasting tool for the management team and senior colleagues. This tool, created by the informatics team, is accessible to the Endoscopy Service management team and other senior colleagues. Pythia generates an ongoing timetable that tracks each endoscopist's scheduled sessions, which is regularly updated to reflect changes in patient lists or provider availability. By running detailed reports, Pythia helps the service develop its annual activity plan with anticipated growth built-in, which is subsequently approved by Trust commissioners.
- Monitoring performance and productivity data for the Endoscopy service has historically been somewhat challenging, with some notable exceptions, such as capacity and demand modelling available through Pythia, KPI monitoring of individual endoscopists using NED, manually performed comprehensive audits etc. However, with the implementation of the Medilogik EMS, the team now has access to more robust data mining capabilities. While regular updates are still provided regarding the delivery of the annual plan developed using Pythia, the EMS system is expected to facilitate more comprehensive performance evaluation and metrics monitoring for the entire service going forward.
- By closely monitoring the capacity and demand for each endoscopy list, the service can adjust the schedule as needed to meet patient needs. The Medilogik EMS system provides valuable data and reporting capabilities to support this ongoing capacity planning and performance monitoring.

5.21.3 Staff recruitment and selection for Endoscopy service

- When a vacancy arises in the Endoscopy service, the Appointing Manager will first ensure that a Leavers Form (ESR3) has been completed for the outgoing post-holder. They will then review the job description and person specification to ensure they accurately reflect the principal roles and responsibilities of the post, as well as the essential knowledge, skills, and qualifications required. The job description and person specification must be in the Trust's standard template formats (see the HR Recruitment and Selection Policy see appendices.
- All vacancies have to be approved via THE REKRUTIMI AND TO be advertised without undue delay, to ensure smooth running of the Endoscopy service, and to prevent staff shortages or inadequate skill mix from affecting the efficiency of the service, as well as patient care.
- If the vacancy identified pertains to senior staff (particularly in senior management roles), the recruitment process should be led in a way that allows for induction of new member of senior staff and an appropriate handover period in between the

staff member leaving and the staff member newly assuming the post.

5.22 Staff recruitment and selection is carried out in accordance with the guidelines as set out in the Trust Recruitment and Selection Policy Professional Development

5.22.1. Induction and mandatory training

- The Endoscopy service aims to ensure that all staff are given the knowledge and skills to work efficiently and safely. Staff are also encouraged to accept (and offered) further training and development opportunities.
- There is also a dedicated Professional Development team working across all the Endoscopy service sites, which facilitates and supports training and further learning of the endoscopy nursing workforce.
- All new staff will have a mentor and will undergo a comprehensive induction program. The formal competency-based induction programme is reviewed annually. Induction is undertaken to ensure all staff, both permanent and temporary, are thoroughly prepared to contribute to the safe and efficient operation of the Endoscopy service. This induction covers key elements spanning the organization, department, and individual role responsibilities.
- At the organizational level, all new Endoscopy staff, including nurses, support staff, and trainees, complete the Trust's standard induction program. This covers essential information such as the Trust's structure, policies, and mandatory training requirements. This ensures a consistent base of knowledge regarding the broader organization.
- Upon completion of the Trust-wide induction, new staff will undergo a dedicated local induction process into Endoscopy. This process is supported by the Practice Development team, as well as staff local to the individual Endoscopy Unit. This is designed to introduce new staff to the specific policies, procedures, equipment, and workflow unique to the Endoscopy service. Emphasis is placed on high-risk areas like infection control, sedation management, and complication recognition and response. Department heads are responsible for ensuring this local induction is thoroughly delivered and documented for all new staff.
- For trainee Endoscopists, the induction process is even more comprehensive. Beyond the organizational and departmental inductions, they also complete a detailed program focused on the clinical and technical skills required to safely perform endoscopic procedures. This includes topics like informed consent, reporting, and management of sedation-related complications. Trainees are not permitted to commence endoscopy lists until this full induction is verified as complete by their designated trainer. Induction of trainee Endoscopists is governed by the Induction Policy for Trainees see appendices.
- Following their induction, staff are required to attend Mandatory Training updates as directed. All staff will complete mandatory training within three months of appointment. All staff are required to maintain 100% attendance at annual mandatory training. This is monitored through the Electronic Staff Record (ESR).
- All staff must attend mandatory fire training, Information Governance, Infection Control as well as basic life-support training annually. All staff are also required to keep up-to-date manual handling competency.
- All Trust staff receive mandatory safeguarding adult and child training to equip them with the knowledge and skills to recognise and report safeguarding concerns,

ensuring a consistent and coordinated approach to safeguarding across the organisation.

- For details of required mandatory training, please see the Trust's Statutory and Mandatory Training Policy see appendices.
- The service ensures all new staff are provided with a nominated mentor/trainer who will supervise them until identified competencies have been achieved to allow them to undertake their role independently.

5.22.2. Nursing staff

- The NMC requires qualified nursing staff to keep their knowledge and skills updated, with revalidation 3 yearly.
- All staff (trained and untrained) receive a formal and informal training programme, this includes internal training sessions and sessions led by external providers (e.g. Manufacturing companies).
- Staff are encouraged to attend external training where funding permits.
- Monthly quality improvements sessions are provided to ensure the workforce are properly trained and competent and meet the requirements for revalidation.
- The service provides a documented matrix of staff competencies for all procedures undertaken. This is clearly displayed within the procedure rooms to ensure safe patient care.
- Each site has dedicated nursing teams. All nurses are encouraged to work across sites to gain new skills and competencies.
- Malvern Community Hospital is supported by the nursing team based at Worcestershire Royal hospital.
- The Matron / Directorate Manager completes an annual training needs plan which will be approved by management and learning & development department.
- All nursing staff are supported in achieving all their competences by both their more experienced colleagues, as well as by direct, regular work alongside dedicated members of the Practice Development team.
- It is mandatory for all nursing and care support staff to complete all relevant JETS Workforce competencies annually and maintain their JETS Workforce portfolio up to date. All new nursing and care support worker staff are expected to complete the JETS ENDO1 connected e-learning within their first three months in their role. Completion of the ENDO1 face-to-face training should ideally be achieved in the same timeframe, but since this is an externally provided course, this is dependent on availability.
- Newly Qualified Nurses will complete the preceptorship programme.
- All Registered Nurses will ensure they continuously maintain their competence in drug administration, confirmation of consent and cannulation

5.22.3 Training and Professional Development

- Every member of staff receives an annual appraisal with their Line Manager or Reviewer (see section 5.22.4 for details). This helps in identifying individual learning needs.

- There is an agreed annual education and training plan which is completed by Endoscopy Unit Managers. The action plans reflect staff and service training/development needs.
- All staff are supported through lifelong learning.

Registered Nurses and Nursing Associates:

- Registered Nurses will complete a formal induction programme which includes the completion of their initial personal development plan within the first 6 months. Registered staff are expected to be fully competent in basic endoscopy skills within 3 months (if working part time, these timeframes are adjusted on a pro rata basis).
- For the intentions and purposes of this document, basic endoscopy competences for registered nursing staff comprise of:
    - competent admission and discharge of endoscopy patients
    - work in endoscopy recovery.
    - competent assistance with basic therapeutic modalities in GI Endoscopy (e.g. taking biopsy, polypectomy, etc.)
    - supporting patient airway during endoscopy
    - basic assistance with achieving haemostasis (including therapeutic modalities relevant for both Lower and Upper GI bleeding).
- Achieving further competences in endoscopic modalities beyond standard Upper and Lower GI endoscopy is both expected and encouraged in all registered staff. This training will be undertaken by staff following their first six-month period, after completion of basic competencies. This process will be guided by service needs and staff personal development plan. More experienced staff are encouraged to develop sub-specialist skills in particular advanced procedures, e.g. ERCP. Every member of the nursing staff will also take on an extended link nurse role.

Clinical Support Workers:

- Clinical Support Workers will complete a formal induction programme which includes the completion of their initial personal development plan within the first 6 months. Clinical Support Workers are expected to be fully competent in basic endoscopy skills within 3 months (if working part time, these timeframes are adjusted on pro rata basis).
- For the intentions and purposes of this document, basic endoscopy competences for Clinical Support Workers comprise of:
    - decontamination of endoscopes
    - supporting registered staff working in endoscopy recovery
    - providing basic support for other staff working in endoscopy rooms during procedures, depending on the specifics of the individual post's job description and pay band.

Student nurses and nurse associates - Supervision and Assessment

- The Trust follows the NMC's "Standards for Student Supervision and Assessment" (2023) to guide the supervision and assessment of student nurses and nurse associates.
- Each student is assigned a Practice Assessor who oversees the entire placement

and conducts the final assessments. Each student also undergoes appropriate induction and orientation to the Endoscopy learning area, in a manner similar to any other temporary staff, but specifically adapted to enhance their learning needs and Practice Placement expectations.

- The Practice Assessor arranges suitable learning opportunities for the student within their scope and stage of learning to meet the course objectives, proficiencies, and learning outcomes.
- Students work with multiple Practice Supervisors who serve as role models, support learning in practice, and provide regular feedback on progress to the student and the Practice Assessor.
- To be a Practice Supervisor, staff members must complete a 1-day workshop provided by the Trust's Practice Facilitator Team, with updates delivered every 2 years.
- To be a Practice Assessor, further training with the University is required (usually the University of Worcester), consisting of a 1-day e-learning and a 1-day taught session.
- Each practice area, including all the Endoscopy Units, is audited yearly to ensure it has sufficient Practice Supervisors and Practice Assessors for the number of students allocated, as well as other support resources such as student information handbooks, Practice Facilitator contact details, and student feedback processes.

Administrative staff:

- Administrative Staff will complete an induction programme.
- Administrative Staff will receive specific internal IT training – use of Allscripts PAS, Medilogik EMS, and all other relevant computer programs and databases.
- Administrative staff are encouraged to progress and undertake courses relevant to their role and/or service, e.g. leadership courses.

Clinical Endoscopists:

- Clinical Endoscopists currently undertaking procedures in the department are from Nursing background and are therefore required to always maintain valid registration with the NMC.
- Clinical Endoscopists will ensure all practical and legal risks have been addressed by undertaking robust training pathways and ensure their operation is agreed by Clinical Governance, as well as the Endoscopy User Group.
- Timely completion of the relevant training programme developed by JAG is an essential requirement for all Clinical Endoscopists. An overview of local training programme requirements can be found in the Induction Policy for Trainees (WAHT-GAS-014, see Appendices).
- In addition to completing their training in endoscopic procedures as required by the Endoscopy service, Clinical Endoscopists are also expected to achieve the following training and competencies: advanced health assessment, and independent and supplementary prescribing. Clinical Endoscopists will be supported by the Endoscopy service in achieving these competencies. This includes provision of allocated study time, clinical supervision, university course funding etc.
- Clinical Endoscopists in training must have a recognised supervisor and a

dedicated trainer. A process of mentoring is strongly advised for all Clinical Endoscopists.

- Clinical Endoscopist will be monitored similarly to Medical Endoscopists against key performance indicators recommended by JAG and will ensure an annual appraisal is completed.

5.22.4 Staff appraisal, personal development review, annual education and training personal development) plan, managing and supporting performance.

- Once a year, all colleagues (including medical staff, nursing staff, care support workers, management, and administrative staff) are required to undergo a formalised personal appraisal, reviewing their progress, and identifying their learning needs and objectives. This is in the form of a Personal Development Review (PDR) with their Line Manager or Reviewer. This is to provide a formal opportunity to reflect on the staff's role and progress, identify objectives for a coming year, explore hopes and aspirations, identify and agree actions to take, evidence the completion of mandatory training, and consider how their actions, behaviour and role contributes to the overall goals and culture of the Trust and the Endoscopy Service. The Trust's Personal Development (PDR) Policy serves as the guiding document to steer the PDR process in the Endoscopy Service (see the HR Policy Manual in the Appendices).
- PDR is also a key mechanism to support and manage staff performance by reviewing overall performance and setting work objectives to support individual staff members, as well as the wider team. Progression through pay points is conditional upon demonstrating the required standards of performance and delivery and that the requisite knowledge, skills and competence for the role have been met.
- The PDR process incorporates relevant information, such as patient and staff feedback, concerns, and complaints, and provides an opportunity to thoroughly analyse and identify future training needs. The PDR process also acts as a mechanism to support medical and nursing staff by generating evidence for their revalidation cycle. A core output of the PDR process is a personal development plan (PDP), with a list of objectives to be completed by the date of the next annualized PDR.
- Apart from helping colleagues to professionally grow and develop, data gathered from appraisals and PDRs is actively utilized to identify and analyse wider training needs within the Endoscopy service, to help pinpoint ways of providing more broad and efficient professional development, such as joint learning events, commissioning of external training, or accredited endoscopy-specific courses.
- PDRs serve also as a safe place to promote staff engagement, and to promote wellbeing through an opportunity to hold staff Wellbeing Conversations (see 5.22.6).
- The Endoscopy service recognises the quality of service and care that its' staff provides for our patients is crucial. In recognition of this, there is a procedure in place to ensure issues around staff performance are dealt with fairly, that steps are taken to establish the facts, and that improvement is supported where called for. The Trust's Performance Policy (WHAT-HR-009) (see the HR Policy Manual in the Appendices) shall be followed to deal with any performance concerns. This policy outlines a clear process involving informal discussions, progress monitoring, and formal stages if required, providing employees with the right to union representation throughout and the possibility of appeal.

- Evidence of undertaking PDRs and completion of PDPs is captured both in staff personal files, as well as electronically through other means, such as Electronic Staff Record (ESR Management self-service), JETS Workforce portfolio, etc.

5.22.5 Staff engagement

- The Endoscopy service aims to assure the delivery of best quality services to patients and users. This can be facilitated by developing an open culture where staff can raise any concerns.
- The Endoscopy Unit Managers, as well as Directorate Managers operate an open-door policy, and staff are encouraged to confidentially raise concerns. The Trust also operates a Freedom to Speak-Up scheme, where staff can raise their concerns anonymously via an independent Freedom to Speak-Up champion.
- All staff are openly encouraged and supported to record any incidents, near-misses, or reportable concerns via the DATIX incident reporting software.
- An endoscopy etiquette guide and code of conduct is visibly displayed in the department and all staff are encouraged to promote a good working environment and promotes a good work-life balance.
- All staff are invited to provide feedback once a year via a questionnaire on how well staff are cared for.
- All staff are encouraged to contribute views and ideas on service developments and discussions are held in the monthly staff meetings.
- All staff are encouraged to participate in the Trust's quarterly staff engagement questionnaire.
- All staff are encouraged to participate in the Trust's annual staff survey.
- All staff are encouraged to undertake staff engagement sessions with the Executive Team.
- Workforce wellbeing questionnaires are handed to staff once a year, with surveys completed and returned. Team engagement is encouraged. Providing the questionnaire enables all staff to ensure they are listened to and respected and able to influence and improve care. The results from the survey are collated and action plans developed to improve on areas highlighted by staff or to give feedback to staff on areas that require clarity. Results are discussed at the directorate meetings and reviewed 3 and 6 monthly.
- Feedback is provided to staff about how their concerns were managed.

5.22.6 Staff safety, support, and wellbeing

- The endoscopy unit promotes a working environment that is safe for employees and patients.
- Health and safety audits are conducted bi-annually and reported back to the Trust.
- Staff are encouraged to complete electronic incident forms via DATIX.
- Incident forms are discussed at the unit morning huddles and at the Directorate meeting. Action plans are completed by staff involved and fed back to the staff meeting to encourage reflective practice and to raise staff awareness.

- Staff to are complete medical device log annually and have their training needs identified and actioned yearly. Specific Endoscopy training is scheduled throughout the year utilising monthly audit days.
- The Endoscopy service promotes health and wellbeing of staff members and staff are encouraged to access staff support services. This includes but is not limited to referring (or self-referring) to occupational health with staff's consent.
- Reasonable adjustments can be made where necessary and feasible, to ensure staff are supported in performing their duties. These can be either permanent or temporary, and include but are not limited to reduction of hours, change to specific tasks, not working on-call, additional training, redeployment etc.
- The Trust is also committed to supporting staff in tackling and reducing sources of workplace stress and providing support for colleagues and managers to reduce it where possible. Managers work proactively to identify potential situations causing stress for staff, identify and respond to concerns promptly. All staff are encouraged to seek assistance and reach out for help as soon as possible, including by speaking to their Line Managers, Occupational Health, Human Resources etc. For more details, please see the Stress at Work Policy.
- All staff are encouraged to access Wellbeing Conversations with their Line Managers / Team Leaders. At the very minimum, this should take place once a year as an integral part of the annual staff appraisal and personal development review (PDR). However, Line Managers / Team Leaders should offer Wellbeing Conversations as often as necessary for the wellbeing of staff. All staff are also encouraged to make full use of all other available health and wellbeing resources, such as Staff Psychological Wellbeing Service, Bereavement support, Working Well service (including physiotherapy), Working Carer support, Childcare and on-site nurseries, Financial Wellbeing Hub etc.

5.23. Training Environment for Endoscopist

- Worcestershire Acute Hospitals provides training for junior medical staff and Clinical Endoscopists.
- This policy provides a brief outline of training support available for endoscopy within the service. For more detailed information and copies of training forms, please refer to the Induction Policy for Trainees see appendices. All trainee Endoscopists will be supervised until deemed competent to practice.
- A list of all trainees and their competencies is clearly displayed in all endoscopy procedure rooms.
- The endoscopy unit will ensure that a training list is supported by nursing staff that have been in their role for a minimum of one year and have completed their endoscopy competencies.
- Learning and training needs must be identified during induction.
- All trainees are given a training pack on arrival in the department, along with a unit induction.
- Where required, endoscopy lists must be reduced/adapted to suit training needs.
- The endoscopy unit will ensure that there are sufficient lists to meet the needs of the trainees.
- All trainees will be supervised by a trainer who has undertaken the Training the

Trainer course (TTT) and registered on JETS. Regular meetings should be held between trainer and trainee to continuously review progress.

- It is the trainee's responsibility to ensure that all assessments are regularly recorded on JETS e-portfolio (in accordance with JAG certification requirements for the endoscopic modality for which they are training).
- An annual unit training survey is undertaken and provides us with future actions for improvement. Trainees are encouraged to attend Endoscopy Users Group meetings and related Governance meetings, as well as encouraged to participate in audit reviews.

5.24. Trainer Allocation and Skills of Trainee Endoscopist

- The Trust training lead is Dr Ian Gee. He takes accountability to ensure that trainees have access to the electronic endoscopy reporting system, as well as JETS Portfolio. He will organise a dedicated trainer depending on skill need and location. He will instigate regular feedback and audit of JETS e-portfolio to ensure appropriate training requirements are met.
- See the Appendices for a list of all trainers who have undergone Training the Trainer course.
- All staff undergoing training must be adequately supervised until they are deemed to be competent to practice alone.
- Individual learning needs must be identified at every meeting between trainer and trainee. An appropriate training plan must be devised, and training given.
- The National and local Trust Guidelines for training of staff in practical procedures are available online and must be always adhered to (e.g. JAG guidelines, Trust safe sedation policy, etc.).
- Trainees are required to undertake a regular audit of their practice.

5.25 Assessment and Appraisal of Trainee Endoscopist

- All trainees undergo a full assessment on arrival and departure from the service and have their training needs identified, and their training planned.
- Trainees will be assessed regularly using DOPS on JETS e-portfolio (in accordance with JAG certification requirements for the endoscopic modality for which they are training).
- Once a trainee has been deemed competent to practice independently, their KPIs will be monitored regularly and reviewed alongside other Endoscopists according to the local audit calendar.
- Endoscopy trainees have an appraisal with their trainer on JETS e-portfolio at least annually. Intermediate appraisal is undertaken at least every 6 months with adjustment of training goals.
- Training lists are actively modified, and action plans documented on DOPS assessments in response to training needs.
- If performance falls below acceptable standards, the Local Training Lead will support and manage performance as per 5.25.1 below.
- Procedure for Dealing with Endoscopist Under Performance. The JAG guidance for managing underperformance is adhered to. Underperformance in endoscopy can

be identified through a variety of methods. Most cases will be detected from electronic audits endoscopy reporting systems or NED KPI's, these are monitored quarterly and shared at EUG. Underperformance may also be directly reported by others such as patients, colleagues including peers and endoscopy nursing staff, indirectly such as through monitoring of KPI's and adverse events or self-reported. The Clinical Director is responsible for reviewing all performance data. Review of underperformance is anonymised and shared at quarterly EUG.

- When identifying underperformance, the safety of the patient is paramount.
- Please note WAHT takes guidance from A framework for managing underperformance and supporting endoscopists – a JAG perspective. Please see appendices.

5.26 Bowel Cancer Screening Programme (BCSP)

WAHT provides Bowel Cancer Screening Programme (BCSP) to the local population(participants) between the ages of 50 – 74.

- Further information can be found in the Bowel Cancer Screening Programme Operational Policy (see Key Documents Server on Trust Intranet).

5.27 Use of agency, insourcing, bank, and locum staff

- Endoscopy services across the whole country continue to face increased demand in activity. The local Endoscopy service is no exception. To meet this demand, the service occasionally employs locum or agency Endoscopists, insourcing companies, or agency-provided nursing staff to meet patient demand.
- The Procedure for Management of patient by Insourcing and Locum providers Standard Operating Procedure -see appendices provides details on the acceptance criteria for the use of agency, insourcing, and locum staff. This is to ensure that patients always receive the same high standard of care quality, irrespective of provider or setting.
- JAG accreditation programme Checklist for services which use insourcing providers stipulates clear requirements to ensure that the commissioning, governance, and operational arrangements are safe and effective for patients who have a procedure performed by an insourcing provider and is transferrable to locum agency. Our Endoscopy services will be required to meet the requirements and submit the listed evidence as part of their accreditation assessment; therefore, a partnership is required to ensure these standards are met.
- The referring medical professionals are responsible for providing full and accurate information when referring patients for endoscopic procedures, so these could be vetted and triaged for appropriateness, as well as clinical complexity, and booked accordingly. The referring clinician is also responsible for submitting referrals compliant with the Endoscopy Referral Guidelines – see appendices.
- The Endoscopy Booking Team is responsible for ensuring that only appropriate patients are selected for insourcing lists. These typically comprise of diagnostic and/or low-risk, low-complexity cases. The Booking Team also ensures that the list composition adheres to scheduling rules and is not overbooked. Additionally, the Team highlights any pertinent patient information on the endoscopy scheduler, such as the need for an interpreter, cognitive impairment requiring consent form 4, anticoagulation therapy, implantable cardiac devices, relevant blood test results, or

medication contraindications for the endoscopic procedure.

- All members of the Pre-Assessment Team will ensure that patients are accurately assessed and deemed suitable for the endoscopy procedure on the insourcing list. They will highlight any additional information on the nursing document, including the need for an interpreter, cognitive impairment requiring consent form 4, anticoagulation therapy, implantable cardiac devices, relevant blood test results, or medication contraindications for the endoscopic procedure. This information will also be communicated to the Booking Team for inclusion on the endoscopy scheduler.
- A Trust Nurse coordinator will be present every time insourcing is conducting a list. They will support the insourcing team in an advisory capacity. They are not part of the clinical team itself. However, they need to be physically present at the site where the list is run and provide guidance on compliance with local policies and procedures, as well as provide orientation to the department. They work alongside the insourcing lead nurse to ensure the list runs smoothly and insourcing staff works to the mandated quality standards.
- Key service operational and clinical documents must be communicated with the insourcing provider including as a minimum:
    - Service operational policy and supporting policies (e.g. consent policy)
    - Decontamination policy
    - Safety reporting procedures
    - Clinical protocols
    - Surveillance / follow up protocols, tattoo policy etc.
    - Emergency procedures including bleeds.
- The Trust Clinical Lead is responsible for overseeing the overall quality of the endoscopists contracted to provide a service, be it as insourcing or as locum. They provide an initial review of KPIs and then continued quality assurance by performance data. The insourcing company or locum agency may be required to provide the whole of practice data for clinicians who appear to be under-performing on their KPI data for activity within the Trust.
- The Clinical Governance Lead is responsible for ensuring all processes have been defined and documentation available for the insourcing teams/agency/locum staff. They are also responsible for monitoring relevant audit data, as well as monitoring and of any incidents occurring. They will liaise with insourcing and locum providers to meet internal investigation processes, as well as ensure any learning gained is shared.
- The Trust Management Team is responsible for minimising agency costs and ensuring value for money. When agency, insourcing, or locum staff are used, the Trust Management Team must provide sufficient resources and equipment to enable these staff to perform endoscopy procedures effectively. Additionally, the Management Team must engage appropriately with insourcing and outside agency management throughout the contract to facilitate service delivery. They will also appoint a named clinician to review direct-to-test patients. Furthermore, the Management Team is responsible for ensuring that clinical findings, such as histology results, are acted upon.
- The insourcing provider/locum agency is responsible for delivering endoscopy services in accordance with agreed upon standards, without limitation to the JAG accreditation programme. They must employ endoscopists that are JAG certified,

who undertake endoscopy as part of their usual clinical practice. They are also obliged to ensure KPI data is collected and reviewed by the insourcing provider to ensure they are compliant with British Society Gastroenterology (BSG) quality and audit standards.

- All insourcing nursing and decontamination staff must be competent to perform the roles they are expected to undertake; those within the procedure rooms should have a background of working in endoscopy. Registrations and PINs of all insourcing staff must be verified and live on the professional register.
- All locum, insourcing, and temporary staff are obliged to undergo induction and orientation provided for them by the Endoscopy service. Usually, this will be either the responsibility of the Trust Nurse coordinator, or of the local Endoscopy unit manager in the case of bank/temporary staff.
- Where bank/temporary staff is used, there must be a justifiable need for this, including the inability to cover the work by the existing workforce, and the fact that service delivery for the patients would otherwise be at risk of being compromised.
- Use of substantive staff should always take precedence before the use of bank/temporary nursing staff, wherever this is practicable, particularly in respect of the skill mix necessary to run high-quality Endoscopy services safely.
- There is an existing Trust policy for the use of bank/agency nursing staff (Use of NHS Professionals Temporary & External Agency Staff – Nursing & Midwifery Policy WAHT-HR-537), which must be followed when using bank/agency nursing staff at all times. This can be found in the Appendices.

5.28 Local Policies (LAST)

Endoscopy units all refer to and adhere to several local policies/processes held within the Trust. These have been named throughout and are available to view in appendices, or via hyperlink.

5.29 Complaints

The Endoscopy Units adhere to the Trust's Complaints Policy & Procedure - see appendices. Compliments, comments, and complaints leaflets are readily available on each Endoscopy Unit, along with patient feedback cards and Friends and Family Test cards. These are discussed at the EUG, Endoscopy Directorate & Governance meetings and fed into Divisional Governance meetings.

6. Implications of non-adherence

Non-adherence to this policy may result in:

- Failure to comply with JAG standards, this will lead to failure to achieve JAG accreditation and loss of income.
- Clinical risk to patients or service or both
- Clinical risk to staff members
- Patients being put at unnecessary risk.
- Financial consequences to the Trust if targets are not met.
- Loss of BCSP
- Increased workloads for all endoscopy teams

- Potential damage to the countywide endoscopy services' reputation, caused by negative patient feedback.
- Increase in patient complaints.
- Poor service to patients

7. Implementation of the Policy

7.1 Plan

- Consultation at Endoscopy Directorate Meeting
- Consultation at unit huddles and unit meetings
- Implementation to be evaluated using agreed monitoring tools.
- Policy will be available in written and electronic form in all endoscopy units.

7.2 Dissemination

- The Policy will be placed on the Trust's Key Documents Intranet page and all staff made aware using the Trust Daily Brief.
- Policy will be distributed to all teams through team briefs.

8. Monitoring and compliance

Monitoring and compliance with this policy is the responsibility of the Endoscopy Directorate.

Monitoring will be conducted as described in the table below:

- GRS Standards – GRS submitted twice yearly. Feedback from JAG regarding accreditation status.
- JAG Audits – Audit Timetable kept and reviewed. Audits checked prior to GRS submissions.
- Patient & Staff Surveys – Annual surveys reviewed prior to GRS submissions.
- Capacity & Demand – reviewed weekly, actions taken if necessary.
- Staff sickness – reviewed and monitored. Matron & Unit Managers receive report from Human Resources.

9. Policy Review

This policy will be reviewed 3 years from the date of approval.

10. References

References	Reference Address/Numbers
JAG, JETS WORKFORCE & JETS website	www.thejag.org.uk
BSG website	www.bsg.org.uk
Code of Conduct for Employees in Respect of Confidentiality.	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1091?persist=False Information Governance Documents

Health & Safety Policy	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1088?persist=True Health and Safety Documents
Security Policy	
COSHH Policy	
Policy for the Provision of Same Sex Accommodation for patients	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1095?persist=False Trust Wide Nursing Documents
Privacy and Dignity Policy	
Chaperone Policy	
Non-Medical prescribing Policy	
MRSA and C.Diff Policies – Within Infection Prevention and Control	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1092?persist=False Infection prevention and Control Documents
Infection Prevention and control Policy	
Clinical Monitoring and Safe Discharge from Endoscopy Policy	
Fire Policy	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1041?persist=True Facilities and Estates
Mandatory Training Policy	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1090?persist=True Human Resources Documents
Training & Development Policy	
Induction Policy	
Sickness Absence, Health & Wellbeing Policy	
Performance Management Policy	
Equality & Diversity Policy	
Bullying & Harassment Policy	
Recruitment & Selection Policy	
Stress at Work Policy	
Controlled Drugs Policy	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1600?persist=True Medicines Documents
Incident Reporting Policy	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1433?persist=True Trust wide Documents
Policy for Consent to Examination and Treatment	
Diagnostic tests – Including requesting, review and filing of results.	
NMC website	www.nmc-uk.org
Cleaning, Decontamination and Validation of Flexible Endoscopes Policy	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1039?persist=True
Clinical Monitoring and Safe Discharge of Patients Attending the Endoscopy Unit Guideline	
Countywide Endoscopy Booking Policy	
Countywide Process Vetting of Endoscopy Referrals to WAHT Units	

Endoscopy Delay to Diagnosis Standard Operating Procedure	Endoscopy Documents
Endoscopy Local Safety Standards for Invasive Procedures (LocSSIP)	
Endoscopy Referral Guidelines	
Endoscopy Standard Operating Procedure for Conscious Sedation Practice in Adult	
Identifying Nursing Roles in the Procedure Room SOP	
Induction Policy for Trainees	
Missed Weekly Water Sample SOP	
Prescribing/Omission of Oral Anticoagulants for Elective Endoscopy	
Procedure for Management of patient by Insourcing and Locum providers	
Training of Registered Nurses to Competently Act as First Assistant with a Registered Medical Practitioner During Placement of PEG	
What to do if a Flexible Endoscope Scope is not Fully Decontaminated for an Endoscopy Procedure SOP	
Identifying and Tattooing Colo-Rectal Malignancy and Polyps	
Antibiotic Prophylaxis in Gastrointestinal Endoscopy	https://viewer.microguide.global/guide/1000000243
Interpreting documentation	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1203?persist=False Patient Led Experience Documents
Concerns and Complaints Policy	
Access Policy	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1931?persist=False Patient Led documents
Standard Operating Procedure for Management of ICD's during Surgery	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1030?persist=True Cardiology Documents
Guideline for the management of diabetes for patients undergoing Endoscopy procedures	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1038?persist=True Diabetes Documents
Guideline for the Management of Adrenal Insufficiency in Adults	http://whitsweb/KeyDocs/KeyDocs/Sub_Webpage/1776?persist=True Endocrinology Documents

11. Background

11.1. Equality

The assessment conducted for this policy reveals no equality issues.

11.2. Financial Risk

Failure of JAG standards will lead to a 5% reduction in the Best Practice Tariff. Failure to

gain accreditation could also mean loss of BCSP and commitment to growth and service development.

11.3. Consultation

Feedback obtained from a broad selection of staff opinions has been sought from Medical Endoscopists, Clinical Endoscopists, Nursing Managers, Directorate Management, and Booking Team Leader.

11.4. Approval

This policy will be approved by the Endoscopy Directorate Group.

Appendix 1: Equality Impact Assessment Tool

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	×	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Karen Bishop	**JAG/Governance Lead**	**karen.bishop12@nhs.net**
Date assessment completed			

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Endoscopy Operational Policy			
What is the aim, purpose and/or intended outcomes of this Activity?				
Who will be affected by the development & implementation of this activity?	✓ Service User ✓ Patient ✓ Carers ✓ Visitors		✓ Staff ❑ Communities ❑ Other _____ ❑	
Is this:	✓ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	There has been a total review of every section, this now complies with all JAG guidance and BSG quality standards. This is referenced at the end of the document			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	This has been a collaborative effort between clinical endoscopists, gastroenterologists, colo-rectal consultants and Upper GI consultants and Directorate Management team.			
Summary of relevant findings				

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		✓		
Disability		✓		
Gender Reassignment		✓		
Marriage & Civil		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Partnerships				
Pregnancy & Maternity		✓		
Race including Traveling Communities		✓		
Religion & Belief		✓		
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		✓		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				

When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**To be reviewed again if any incidents occur which result in Datix or when the policy is next due for review.**

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	
Date signed	03/10/2024
Comments:	
Signature of person the Leader Person for this activity	
Date signed	03/10/2024
Comments:	

Appendix 2: Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.