Policy		NHS Worcestershire Acute Hospitals NHS Trust

INDUCTION POLICY FOR TRAINEES

Department / Service:	WORCESTER ACUTE HOSPITALS NHS TRUST
Originator:	Karen Macpherson
Accountable Director:	
Approved by:	Endoscopy Governance Meeting
Date of approval:	5th July 2023
Expiry Date:	5th July 2026
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Endoscopy Department
Target staff categories	All staff working within the Endoscopy Department

Plan Overview:
This policy document is for all new endoscopists, whether as a trainee or independent practitioner, so that you can get a head start in the department. We have based this policy on the GRS standards from JAG for the delivery of training, including the responsibilities of both the trainers and the trainees.

Key amendments to this Document:

Date	Amendment	By:
5th July 2023	New document Approved	Endoscopy Governance

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1. Introduction

Welcome to the Worcestershire Endoscopy units. There are four units within the Trust: Endoscopy Unit Alexandra hospital, Endoscopy unit Worcester Hospital, Kidderminster Treatment Centre, and Evesham Community Hospital. In addition, we have Malvern Community hospital which is the Bowel Cancer Screening Centre (BCSP). The Alexandra, currently has two procedure rooms, but we expect work to begin soon on the new unit which will have three rooms. Worcester and Kidderminster have three rooms (soon to be extended to 5 rooms). Evesham has two. The majority of emergency call outs are at Worcester but both Worcester and the Alex have an on call service. In addition to GI endoscopy, Bronchoscopy lists are held on the Worcester and Alex sites. Evesham do GI diagnostic service and KTC have GI endoscopy and they also have cystoscopy lists there. The units are staffed by a multidisciplinary team with GI physicians, surgeons and nurse endoscopists. They may all be involved in training you.

2. Scope of the policy

- To ensure that regular provision is made to meet the training requirements of all endoscopy trainees
- To ensure that trainees have supervision and development plans appropriate to their stage of training
- To ensure that only trainees who have been assessed to be competent for specific procedures are permitted to practice independently within the endoscopy unit
- To comply with current national JAG, Royal College and National Endoscopy Training Programme recommendations

3. Definition of key words

JAG	Joint Advisory Group
GRS	Global Rating Scale
BCSP	Bowel Cancer Screening Programme
GI	Gastro-Intestinal
JETS	JAG Endoscopy Training System
DOPS	Direct Observation of Procedural Skills
ARCP	Annual Review of Competence Progression.
CCT	Certificate of Completion of Training
DOTS	Direct Observational Training Skills
MDT	Multi-Disciplinary Team
CRC	Colo Rectal Cancer
UC	Ulcerative Colitis

4. Responsibilities & Duties

- An accurate log book of experience (JETS web site) registration required
- A record of courses attended
- All formative DOPS completed for that procedure (JETS website)
- Feedback on each session is required (JETS web site) **If this is not completed within 3 weeks of each list then training lists will be cancelled.**
- A record of level of supervision required/ independence for each endoscopy.
- Initial, midterm and exit interview records
- A record of sedation used, complications and specific audit criteria relevant to each endoscopy type.
- Please find JETS user guide for trainees **(Appendix viii)**

5. Policy Detail

To provide an overview of training and service within Worcester Acute NHS endoscopy units.
On the last Friday of every month 10-10:30 there is a welcome session from the SCSD divisional management team in an open and informal way. For link to the session see **(appendix iv)**

5.1 Assessment of skills for supervised training or assessment of competence/ independence: -

So that we can meet your training needs, every new appointee will undergo a period of review during the first few weeks of the job. This is to enable supervision to be provided at the right level for your competence, and areas that require special attention identified. To help in this process we ask that specialist registrars complete the baseline endoscopy questionnaire with your trainer, or training lead. **(appendix i)**

For those previously signed off as competent in previous jobs, we will review your documentation with the baseline questionnaire, validate your competencies and develop learning objectives for your placement. Your first few procedures or lists may be supervised and a DOPS forms completed. All trainees will repeat this process over the course of their appointment so that new goals can be set and so that we can adjust training to meet your needs. Following assessment by a trainer a decision will be made as to the level of further supervision you require.

For specialist registrars, feedback documentation can be submitted in support of your ARCP and for your CCT.

Supervised hands on training:
From before your first endoscopy, hands on training is defined as all training to the point at which you have had a successful summative assessment for provisional JAG accreditation by two assessors and your log book has been classed as satisfactory. Worcestershire Endoscopy Service uses the JAG DOPS assessment criteria for assessment **(Appendix vi)** You must not perform endoscopy unless your trainer is present in the room with you.

5.2 Summative assessment for provisional JAG certification (Colonoscopy: -

After a training period, or review of your skills, your trainer can arrange to have your training and competence level assessed once you have completed a certain amount of endoscopies, provided audit data and feels confident to perform that specific procedure independently. A signed trainee register form must be displayed in the Endoscopy procedure room **(Appendix v)**
You may then scope whilst a trainer is in the department or elsewhere in the hospital. Further endoscopies and audited data are required**.**

JAG Certification is a two-part process, with Provisional JAG Certification followed by a shorter period of advanced, targeted training prior to FULL JAG Certification. This applies to Colonoscopy only, OGD is a single stage sign off process.

Full details can be found at www.thejag.org.uk

5.3 Summative assessment for full JAG accreditation (colonoscopy): -

This is to assess your full quota of colonoscopies and audited data for completely independent practice in that skill, as per JAG. Your trainer will assess you and review your data, and arrange two assessors to validate your work and audit. This will allow you to perform that specific procedure independently without supervision and submit a final form to JAG. Summative DOPS forms on JETS website.

Trainees who have full JAG summative certification, your trainer will review your skills on one list, which may be used as evidence as ongoing peer assessment for your JAG portfolio.

5.4 Countywide Training Lead: -

The nominated training lead, Dr Ian Gee and he is based at Worcester Royal Hospital. Contact details can be found on the contacts page. **(appendix ii)**

The role of the training lead is to: -

- Ensure the endoscopy units are appropriate environments for learning.
- Work within the team to balance the training agenda and GRS training

domain against service requirements and GRS clinical domains. (**Appendix iii)**

- Co-ordinate an induction programme for new trainees, with regular updating.
- Co-ordinate the initial assessment of trainees
- Maintain a register of trainee competencies and training needs
- Co-ordinate training list allocation and adjustment according to trainees' requirements
- We will hold bi-annual meetings to discuss trainees and trainers based on the feedback provided in the DOPS/DOTS. Trainee

5.5 Trainers: -

You will have a nominated trainer who is responsible for your endoscopy training and development during your allocation.

Your trainer will: -

- Follow JAG guidance on training
- Undertake your induction programme
- Establish your learning contract and needs
- Meet with you and review progress at least six weekly
- Undertake induction, midterm and exit interviews for training
- Use DOPS assessments regularly to feedback on your performance
- Liaise with colleagues to provide your summative assessments
- Participate in trainer updates including attending Training Endoscopic Trainer Courses, at a designated JAG centre for training
- Meet GRS training domain requirements
- Undergo peer assessment as a trainer
- Participate in processes for trainee feedback of their performance as a trainer
- Any nominated trainer will be invited to teach on the academy training course, to fulfil the GRS standards.

5.6 Unit Responsibilities: -

The endoscopy unit staff (nursing and administrative) should:

- Bring to the attention of the lead endoscopy trainer if there are any concerns regarding training
- Ensure that an appropriate number of points is allocated for each trainee, following confirmation from the trainer
- Ensure only trainees on the register within each room are allowed to scope with or without supervision accordingly

5.7 Trainees & Responsibilities: -

To ensure the safety of patients, we expect you to agree to the induction and training programme. You may not undertake endoscopy until your trainer has completed your induction programme, or you can provide evidence all elements have been completed elsewhere.

Whilst you are training in a procedure prior to first summative assessment, you are required to have your trainer in the room with you.

You must keep a portfolio of assessed cases for all procedures according to JAG guidelines. (JETS database)

Your learning contract is driven by your needs, and what you want to achieve. We will help to facilitate this into manageable outcomes, but the learning is led by you as a trainee.

All endoscopies should be recorded in your own name (to allow for clinical audit required by GRS)
Endoscopist 1 Should be the training lead for that list
Endoscopist 2 Is your name as the clinician completing the procedure.

Trainees should arrange meetings with their trainer to review progress and discuss future goals. You may undergo a midterm assessment of your skills and progress and if necessary adjustments can be made to future lists according to trainees needs.

You must inform with your trainer, the Endoscopy Unit Manager, the Endoscopy Admin Team Leader, Service Support Manager and List Co-ordinator at least six weeks in advance if you are not attending a training list.
Feedback from trainees can provide valuable information on the quality of training. During your training, you will be asked to comment and score on your trainer's knowledge, skills and attitudes (**see appendix iii**).

It is the trainee's responsibility to arrange attendance at other meetings and events e.g. MDT to provide evidence for full JAG submission**.**

If you are concerned about your training, learning environment or your trainer's performance, you must discuss it with either the training or clinical lead.

6. Endoscopy Induction: -

Endoscopy induction forms two parts: -

Part A – Orientation and safety. (Trainees responsibility) prior to commencement of endoscopy lists
In order to maintain patient safety, you must visit the Endoscopy Unit, introduce yourself to your trainer, the Endoscopy Unit Manager and Admin Lead/Booking Team. You must complete this part prior to commencing procedures in the department. Your name will be added to the Unisoft Endoscopy Reporting System (Dr Gee to be contacted) to allow you to record and audit your endoscopies.

Part B – Clinical skills and associated knowledge. Trainees and designated trainer

This is based around the JAG guidance for training in endoscopic procedures, and will be assessed within the DOPS forms and review of portfolio of evidence (remember to register).

The induction will cover:

- Undertaking informed consent from patients with a wide range of educational and ethnic backgrounds. This includes withdrawal of consent
- Communicating their endoscopic findings and implications to patients, relatives and colleagues. This includes providing high quality written endoscopy reports
- Delivering safe conscious sedation as well as managing sedation-related complications
- Recognising, managing and avoidance of endoscopy related complications including antibiotic prophylaxis, indications and contraindications to endoscopy and safe use of diathermy
- More detailed discussion and use of local and national policies for patient management
- Ensure awareness of correct Endoscopy referral forms and use of Trust Intranet – Document finder for policies relevant to Endoscopy

All units work to standards outlined within the Global Rating Score, which is a continuous and moving process. You may be asked to undertake some project work related to this during your training allocation. As part of this, there is an audit cycle which links in with the Unisoft system (see appendix iv).

6.1 Clinical Guidelines relevant to the Endoscopy Unit

There are a number of clinical guidelines available electronically, accessible via the Trust intranet, and in paper format in each Endoscopy unit. Part of your training is to familiarize yourself with these, when you would use them and how to deal with situations outside the guidance.

1 Safety in sedation
2 Antibiotic prophylaxis in endoscopy
3 Anticoagulants and antiplatelet therapies in endoscopy
4 The diabetic patient
5 Cardiac disease in endoscopy
6 Respiratory disease in endoscopy
7 Gastrointestinal haemorrhage and endoscopy
8 Consent
9 Surveillance guidelines

6.2 Endoscopy Courses and additional resources: -

As part of your endoscopy training, and in readiness for your certificate of completion of endoscopy training, and your Royal College CCT, you are required to attend JAG approved endoscopy courses. All trainees are supported in attending, a list of centre's can be found on the jets website

- Basic Skills in Endoscopy
- Basic Skills in Colonoscopy
- Trainees undertaking therapeutic procedures are required to attend advanced courses (Therapeutic Upper Endoscopy, Advanced Colonoscopy Course, Basic ERCP Course)

These courses can be accessed via the JAG / JETS website (see useful website details). Your trainer will advise you on which one is required for your level of training, and if financial support is available.

7. Regional Training Centre: -

Wolverhampton is our Regional Training Centre for Endoscopy training, and KTC is a Spoke Centre. The courses we will be offering are

- Basic skills in endoscopy (OGD and flexible sigmoidoscopy)
- Basic skills in colonoscopy
- Supporting the trainers
- Training the colonoscopy trainers (commencement date to be confirmed)

You are expected to develop your skills and knowledge around endoscopy and its related professional fields.

7.1 Endoscopy Lists

Training lists are booked with fewer procedures to facilitate endoscopy training. All other lists are service lists. Trainees are encouraged to lead the list under supervision when they reach a level of competence, but do not feel put out if time considerations mean handing over to the supervising consultant when a difficult case is encountered.

The training lead and coordinator will plan your training sessions in endoscopy following your initial interview. This will link into your service commitments/on call/nights for the following month. This allows fair distribution of training lists, in addition to ensuring list space is used effectively. Access to supervised training lists is coordinated by the booking coordinator for that unit

Some endoscopy lists are "pooled" meaning you will be scoping various clinician's patients and returning them to their care.

7.2 Arranging Endoscopic procedures: -

As a trainee, you will probably be requesting endoscopy procedures. The current system, which links into the national and local targets and service improvement are as follows:

There are options of priority for patients:

31/62 day and 2ww pathway:

- Will be undertaken ASAP and within 2 weeks.
- Please identify patients that are on either of these pathways

Urgent:

- Will be undertaken within two weeks

Routine:

- Will be undertaken within five weeks six days' maximum

Please do not mark cards urgent or 31/62 unless this is true, or there are valid reasons for expediting a case.

It is important to indicate on the referral if the patient has any special requirements e.g.:

- Frail elderly who may need inpatient bowel preparation prior to colonoscopy
- Unstable diabetics who may need admission prior to procedure
- Anticoagulated patients needing therapeutic procedures and adjustments to their regimen
- Language or disability interpreter required.

For inpatients, an endoscopy request form must be completed and delivered to the endoscopy nursing team, it must also be documented in the patient notes that a request has been sent. In-patient referral forms are kept on the wards. In-patients will be scoped within 24-48 hours.
Patients may be sent home and an endoscopy arranged as an outpatient as above.

Please note ALL endoscopy referrals must be typed. Handwritten referrals will be rejected.
All typed referrals must also be sent electronically to the booking email addresses. The only exception to this is any in patient referrals these must still be typed and brought to the unit to discuss with the teams.

7.3 Consent: -

The formal signing of the consent form for outpatients is obtained on the day of endoscopy, all trust sites use e consent, and nurses confirm consent on the day of test, unless patients have not read information sent to them or are unable to consent. In-patient consent should be obtained before the patient reaches the endoscopy unit. All consent forms must be deemed therapeutic consent forms; therefore, any procedure being carried out should include intended therapies ie: control of internal bleeding; polypectomy or EMR. These should be produced via E-Consent or handwritten on a blue consent form 1 complete with risks and benefits to enable the patient to be fully aware of what to expect.
In line with Trust policies, the following statements need to be considered when obtaining consent:

- **All adults are presumed to have capacity unless proved otherwise. Consequently, informed consent is essential before examination or treatment.**
- There is a legal right to refuse treatment and no reason need be given
- The only exception to this is treatment for a mental disorder where the patient is detained under the Mental Health Act 1983.
- If an adult lacks capacity, the principles of the Mental Capacity Act 2005 should be adhered to.

8. Histology: -

Histology should be addressed to the referring clinician. An ICE request must be generated for all histology requests.

The following biopsy schedules are followed using national guidelines.

8.1 Barrett's Oesophagus: -

Histology is sent to the referring consultant. The results determine the surveillance interval for the next endoscopy. These should be booked at the time of the endoscopy, if they are subsequently not required based on histology results, then surveillance may be cancelled at a later date. This will prevent patients being missed off the surveillance programme. Please follow BSG guidelines for Barrett's oesophagus **(Appendix ix)**

8.2 Gastric Ulcer: -

Gastric ulcers should be biopsied and re-evaluated after appropriate treatment, including H. pylori eradication where indicated, within 6–8weeks. Where a gastric ulcer is seen during an OGD, this should be fully assessed, including a description of the size and location. Helicobacter pylori status should be assessed by a rapid

urease test or gastric biopsies, and if appropriate, eradication therapy should be prescribed. A repeat OGD to ensure that the ulcer has healed should be performed 6–8weeks after the index OGD.

8.3 Duodenal Ulcer/ suspected H pylori infection: -

Where gastric or duodenal ulcers are identified, H. pylori should be tested and eradicated if positive. Where gastric or duodenal ulcers are observed, H. pylori should be excluded by a rapid urease test or gastric biopsies. Medication history should be reviewed to exclude contributory pharmacological agents such as non-steroidal anti-inflammatory drugs. There is no role for the surveillance of duodenal ulcers, with repeat OGD having a low diagnostic yield.

8.4 Ferritin deficient anaemia/positive TTG: -

Where iron deficiency anaemia is being investigated, separate biopsies from the gastric antrum and body should be taken, as well as duodenal biopsies if coeliac serology is positive or has not been previously measured. Iron deficiency anaemia has been found to be associated with gastric atrophy. We suggest biopsies are taken from the gastric antrum and body to confirm this diagnosis and avoid further unnecessary investigations. Biopsies from the duodenum should also be taken if coeliac serology is positive or has not been measured before an OGD performed for iron deficiency anaemia.

8.5 Suspected GI malignancy: -

Any lesion that has a malignant appearance should be sampled with 6-8 biopsies. Write “URGENT” on the histology form or “2WW” if the patient has been referred via the 2 week wait system.

8.6 Surveillance for CRC in patients with extensive/total UC and Crohn’s colitis: -

4 biopsies should be taken every 10cms or from every section of the bowel or be guided by dye spray AND/OR biopsies of abnormal mucosal areas. Chromoendoscopy/ narrow band imaging may be used. (BSG)

8.7 Unexplained diarrhoea: -

Even in the presence of normal looking colonic mucosa, biopsies should be taken from the left and right colon, and rectum to rule out microscopic colitis. As per BSG guidelines.

9.Tattooing: -

Tattooing is recommended for the following situations: - (NICE)

1. Any high risk polyp or suspected malignant polyp
2. Any large (generally > 20mm), flat polyps that are removed via endoscopic mucosal resection (NB use Indigo carmine to raise the polyp)
3. Any smaller lesions that are not removed at the index colonoscopy (rare as all lesions should be dealt with at the index colonoscopy)
4. There is no need to tattoo lesions within the Caecum or Rectum.

At least two sites should be tattooed.

10. Radiology: -

- All patients that are referred on the 31/62 day or 2ww pathway must be identified.
- Should a patient require radiology examinations, such as CTC for incomplete colonoscopy, 2 week wait radiology, it is the responsibility of the endoscopist to organise further examinations. In the case of Rectal malignancy MRI should also be requested.

11. Follow up after Endoscopy: -

Many patients do need follow-up after endoscopy. It is important to make this clear at the time of the procedure and to follow the instructions given on the last letter or endoscopy referral form. If you are unsure, the notes can be returned to the referring consultant for a decision to be made regarding follow-up in light of the endoscopic findings, with or without associated histology.

12. Rebooking surveillance patients: -

All units undertake surveillance endoscopy. All patients having surveillance endoscopy are clinically and administratively validated, which may mean the request is refused if it does not meet the unit guidance. Below offers a working summary of what you need to do once an endoscopy has been completed.

12.1 Ulcerative colitis/Crohns disease patients: -

After endoscopy, follow BSG guidance on timing for next endoscopy. **(Appendix x)**

12.2 Polyp surveillance: -

If histology/ polypectomy is undertaken, send the results to the referring clinician. This will determine surveillance interval for next endoscopy.

If no polyp found on a patient on polyp surveillance, follow BSG guidelines/ map of medicine for the next endoscopy. This may be requested from the unit with clear information as to why it is required. **(Appendix x)**

12.3 Colorectal cancer/Post-surgery surveillance: -

Follow current BSG /NICE network guidance **(Appendix xi)**

13.Patient Safety:

13.1 Sedation: -

In line with British Society of Gastroenterology guidance, please note the key safety points:

1. In patients 70 or under
    a. Midazolam should be given in titrated doses starting with 2mg up to a maximum of 5mg
    b. Fentanyl should be given in titrated doses starting with 50mcg up to a maximum of 100mcg
2. In patients over 70 less sedation is required
    a. Midazolam should be given in titrated doses starting with 1mg up to a maximum of 2.5mg
    b. Fentanyl should be given in titrated doses starting with 25mcg up to a maximum of 50mcg.

The opioid should be given first and the effect observed before giving Midazolam. These doses should be altered if the patient has co morbidity or is ASA 3 or above. It is rare to give doses higher than this the exception being in EUS and possibly ERCP.
Average sedation usage is audited, and your results will be incorporated into your trainer's results as part of GRS.

13.2 Antibiotics: -

Risk of bacteraemia following an endoscopic procedure is dependent on the type intervention given at the time of the endoscopy. Both units follow BSG guidance which can be found in the training file and guidelines file and on desktop on each room.

13.3 Anticoagulation: -

The trust Endoscopy Service adheres to the BSG guidance on anticoagulation and anti-platelet management in endoscopy which should be followed at all times. **(Appendix xii)**

13.4 Diabetes:

Please follow guidance set out in trust policy for management of diabetes in endoscopic procedure. **(Appendix xiii)**

13.5 Cardiac and respiratory disease: -

The hypoxia and stress of an endoscopy can exacerbate cardiac ischaemia. Endoscopy should be avoided immediately after and acute coronary syndromes for 3 months. If the patient has an upper GI haemorrhage, a balance of potential benefit from an endoscopy has to be weighed against the potential harm. Patients with respiratory diseases may have resting saturations of less than 94%. In these patients, sedation carries a high risk. Consider alternative investigations (e.g. CT colon). In urgent cases (e.g. acute gastrointestinal haemorrhage, the potential benefit has to be weighed against the potential risk on an individual basis). **Seek advice from a consultant colleague on proceeding.**

14.Frequently asked questions: -

I am a new trainee who hasn't undertaken any endoscopy before: -
You need an identified trainer to supervise all your endoscopy practice. Your clinical supervisor should arrange one for you. If you are unsure, contact training leads above.

I am a trainee who has done some endoscopy in other units, but not used DOPS before: -
Examples of DOPS forms and the descriptors used can be found on the JETS website. Arrange a list where you will have a number of cases assessed using DOPS forms. You will need a baseline interview.

I am a trainee who has done some endoscopy a few years ago in a previous job: -
Show your trainer your log book of previous experience and numbers at your baseline interview. They will guide you whether you need further supervised training or can go for a summative assessment.

I am a trainee who has been "signed off" in my previous job: -

At your baseline interview, show your trainer your log book and any documentation from previous jobs. You will only be classed as "fully signed off "i.e. independent if you have a final summative certificate from JAG. You may find your trainer recommends you require a provisional or final summative assessment in line with JAG recommendations and Trust policy.

I am a trainee who can do one type of endoscopic procedure, but would like to learn another:
Discuss with your trainer at your baseline assessment.

I am a trainee who has done a lot of endoscopy, but has always had a supervisor in the room: -
You may be ready for a summative assessment to practice with a distant supervisor or completely independently. Have your log book ready for your baseline assessment, and audit your completion/ sedation practice as per JAG guidance. Your trainer may undertake a DOPS assessed list to help determine if you can be recommended for a summative assessment.

I am a trainee who has undertaken endoscopy training abroad. I do not have a log book of cases: -
Try to identify your numbers, and see if you can get a written statement form previous clinical supervisors as to your practice abroad. At baseline assessment, your trainer will organise a DOPS assessed list to establish your level of competence prior to you being recommended for further training or a summative assessment.

I am about to move posts and want to evidence my endoscopy experience to continue my training: -
As part of your exit interview, your trainer will complete with you a statement of learning and endoscopic experience for you to take to your next post.

I have been asked to complete an evaluation of my trainer's ability to train. What do I do?
The KSA (knowledge, skills, and attitude) evaluation ensures the high quality of training is maintained. All trainers agree to have these evaluations performed by trainees and by their own training peers at least bi annually. Your comments are anonymous. All feedback can help improve practice.

15. Implications of Non-Adherence to Policy

- Patients being put at risk.
- Staff being put at risk.
- Poor service/impact on the service leading to financial consequences.
- Conversation of concern/ disciplinary actions from training lead.

16. Implementation of the Policy

The policy will be implemented with immediate effect following approval.

17.Dissemination

- The policy will be discussed at the Directorate meeting.
- The policy will be placed on the Trust's Endoscopy Intranet page.
- The Policy will be sent to individual trainees upon commencement of course.

18.Appendices:

Appendix Number	Document
i	Registrar Starting Form.docx
ii	Contacts pages for Induction document.d
iii	GRS standards for training.docx
iv	Meet the Team SCS DMT Poster V2.pdf
v	Trainee register form.xlsx
vi	DOPS and DOPyS form and JAG certifica
vii	JETS User guide for trainees.pdf
ix	BSG-guidelines-on-th e-diagnosis-and-man

x	BSG-IBD-Guidelines-2019.pdf
xi	Appendix-5-surveillance-algortihm post col
xii	BSG_ESGE-antiplatelet-and-anticoagulant-u
xiii	Diabetes in endoscopic procedure guidelines.docx

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	• Ensure all areas are visibly zoned with posters and appropriate PPE station at each point • Identify any issues/problems and report through correct channels. • Ensure all staff are compliant and understand new processes to follow	• In charge person to oversee on daily basis compliance of new process to follow	• Daily	• Endoscopy unit managers/ matron/Diectorate Manager	• Endoscopy Mangement • Endoscopy Directorate Meeting	• Weekly Directorate meeting

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Dr Ian Gee Consultant Gastroenterologist Training Lead
Dr Amul Elagib Consultant Gastroenterologist
Dr Danny Cheung Consultant Gastroenterologist
Mr Bala Reddy Consultant Colorectal Surgeon
Mr Richard Lovegrove Consultant Colorectal Surgeon Endoscopy Clinical Lead
Mrs Lynne Mazzocchi Directorate Manager
Mrs Gina Gill Deputy Directorate Manager
Mrs Julie Mathew Lead Clinical Endoscopist and Nurse Endoscopist Training Lead

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
Directorate management team
Training committee Lead Dr Ian Gee

Supporting Document 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	**Karen Macpherson**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Karen Macpherson	**JAG/Governance Lead - Endoscopy**	**Karen.macpherson5@nhs.net**
Date assessment completed	**25/09/23**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Endoscopist Induction Policy**
What is the aim, purpose and/or intended outcomes of this Activity?	To give guidance and clarity

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.	BSG JAG JETS			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Dr Gee Julie Mathew			
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		✓		The implementation of this policy will not impact the user
Disability		✓		The implementation of this policy will not impact the user
Gender Reassignment		✓		The implementation of this policy will not impact the user
Marriage & Civil Partnerships		✓		The implementation of this policy will not impact the user
Pregnancy & Maternity		✓		The implementation of this policy will not impact the user
Race including Traveling Communities		✓		The implementation of this policy will not impact the user

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Religion & Belief		✓		The implementation of this policy will not impact the user
Sex		✓		The implementation of this policy will not impact the user
Sexual Orientation		✓		The implementation of this policy will not impact the user
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		✓		The implementation of this policy will not impact the user
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)		✓		The implementation of this policy will not impact the user

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)				

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	
Comments:	
Signature of person the Leader Person for this activity	
Date signed	
Comments:	

Supporting Document 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 which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval