Joint Advisory Group on Gastrointestinal Endoscopy (JAG) achieves enduring large-scale change

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It is nearly 20 years since the national colonoscopy audit demonstrated poor performance of colonoscopy and inadequate training of colonoscopists.[1] In 2004, a National Confidential Enquiry into Perioperative Deaths in endoscopy identified major deficiencies in the service.[2] These two seminal publications identified what the endoscopy workforce in the UK already knew: the service was falling well behind endoscopy services in other countries and delivering poor care to patients. There were multiple problems: inadequate facilities and equipment; long waits and poor patient experience; inadequately trained staff; minimal or no processes to ensure appropriate patient selection and safety; and no monitoring of quality.

During the period 2001–2010, the endoscopy service in England received substantial national investment targeted at modernising the service and improving training, especially colonoscopy training.[3] During the same period, bowel cancer screening programmes were implemented in each of the four nations. The challenge was to use the new money and impetus from screening wisely: to deliver clear improvements; and to achieve a sustainable position when investment was withdrawn. The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) has played a pivotal role in addressing this challenge, directing the service and empowering it to change.

The JAG was created in 1994 to support endoscopist training. Prior to 2001, its main responsibility was to accredit endoscopy units for training using a self-reported paper questionnaire. Basic requirements of training were made clear, but the standards were not enforced, and units that did not have the JAG 'badge' continued to train. The impact on training was modest at best.

However, the JAG was truly multiprofessional, and perfectly constituted and placed to expand its role to become the governing body of the service: setting policies and standards; directing and driving change; and setting up quality assurance infrastructure. With the support of its parent medical and surgical professional organisations, the Bowel Cancer Screening Programme, the National Endoscopy Team and the leaders of the newly formed national training programme, the JAG changed its approach, creating a model for multiprofessional leadership of a clinical service.[3] At the centre of its approach was an accreditation scheme for service delivery and endoscopist training: an enduring solution for sustaining improvement once the central funding ran out.

It is timely to look back and reflect on the impact JAG has had and review evidence of enduring improvement in quality. Determining what makes a difference within a moving landscape of healthcare, particularly ever changing national policy and service reconfigurations is a difficult task. Randomised controlled trials are not easy to perform in this situation and their results are often out of date before they are published. We have to look therefore for proxy evidence of which there is plenty, and compare progress with other jurisdictions (quasicontrols) that do not have a JAG equivalent.

The review by Siau and colleagues brings together, for the first time, the published evidence of JAG-related activity and impact during the last 10 years.[4] The authors have employed a structured approach to the identification, review and presentation of publications. A high proportion of quoted evidence is still in abstract form. Nevertheless, the review paints a picture of wide-ranging impact and influence, both within the UK and beyond. The JAG has put in place enduring processes and infrastructure such as certification of endoscopists, the e-portfolio and accreditation of services that hardwire excellence into the service. These changes have been designed to minimise the burden on the service while maximising their impact. With perhaps the exception of the Dutch approach[5] to quality assurance of bowel cancer screening (much of which is based on JAG methodology), no other country or professional body has come close to what the JAG has achieved in the UK.

When change occurs it is very easy to get used to the new norm and take for granted what is different and what influence the changes have had on the wider system, both here and abroad. For example, within England the JAG accreditation programme is known beyond the service for its innovative approach and regarded to be a model for other schemes. Its success has stimulated the development of a multiprofessional strategy for service-based accreditation schemes across all of healthcare, led by the Clinical Services Accreditation Alliance.[6 7] The JAG has been working closely with the regulator (Care Quality Commission) to determine how accreditation can help inform and reduce the burden of inspections. This work will set down key principles and processes that will underpin the future relationship between professionally led accreditation of clinical services and regulation of healthcare. The regulator using accreditation to support its inspection regime will accelerate creation of new schemes in other clinical services. This will lead to enduring improvements in patient care, as has happened in endoscopy.

Siau and colleagues provide numerous examples of JAG influence abroad and in other specialties, including adoption and adaptation of JAG-inspired training courses[8–10] and endoscopy service standards. There are now several international publications exploring the utility of the endoscopy Global Rating Scale (GRS). The GRS has been the starting point for Canadian, American and European guidelines on standards for endoscopy services.[11–13] It is also clear, at least to this author, that other nations would find it easier to implement these guidelines if they had a multiprofessional governance body like the JAG.

So what of the future? Despite huge progress the endoscopy service in the UK remains under pressure as demand for endoscopy rises, as new technologies become mainstream and as requirements (such as those for decontamination and single sex accommodation) become more demanding. To make matters worse, endoscopy is working (and competing) within a challenged and perpetually under-resourced healthcare system. Never has it been more important to have strong leadership at national level that offers guidance and processes to support the service, which provides evidence to patients, payers and regulators that it is doing a great job and that is always looking for ways to improve. The JAG is well placed to meet this challenge, leading the way in quality assurance of service delivery and training.

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