FAQs on paediatric colonoscopy competency pathway

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1. How many colonoscopies do I need?
You need ≥150 lifetime procedures, with ≥50 performed in the preceding 12 months. Up to 30 flexible sigmoidoscopies can contribute to the lifetime total, provided they are accrued in Stage 1.

2. Can flexible sigmoidoscopies count?
Yes — up to 30 can count towards the 150, but only within Stage 1. Importantly, paediatric colonoscopy DOPS cannot be performed on flexible sigmoidoscopy cases.

3. Is certification based simply on reaching 150 procedures?
No. The pathway has three sequential stages: Stage 1 focuses on reaching/passing the transverse colon; Stage 2 on progression beyond the hepatic flexure; and Stage 3 on independent complete colonoscopy including terminal ileal intubation. A trainee progresses to the next stage only after satisfying the preceding stage's requirements.

4. Why does the pathway require 150 lifetime procedures when the three stages specify only 130 procedures?

The stage-specific minimum requirements are:

The overall lifetime requirement is at least 150 procedures, leaving a difference of 20.

DOPS are assessments undertaken during procedures and would ordinarily be expected to count towards procedural experience, rather than necessarily requiring additional procedures.

The four summative DOPS are completed after meeting the eligibility criteria and must be undertaken within one month, with all items scored as competent for independent practice.

Trainees must achieve both the stage-specific requirements and the overall 150 lifetime procedures. The 20-procedure difference should not automatically be interpreted as 20 additional DOPS cases.

5. What counts as "unassisted"?
For the certification metrics, the procedure needs to be achieved without physical assistance from the trainer.

The current pathway explicitly states that DOPS cannot be performed on procedures where the trainee was physically assisted.

6. Can a formative DOPS be completed when a trainee performs part of the colonoscopy but the trainer subsequently takes over?

The pathway explicitly states:

DOPS cannot be on procedures where physically assisted.

This restriction does not distinguish between formative and summative DOPS. Therefore, on a literal interpretation, it applies to both.

During Stages 1 and 2, however, the required competencies are different from those expected of an independent colonoscopist.

Stage 1: Five DOPS demonstrating successful passage beyond the splenic flexure into the transverse colon.

Stage 2: Five formative DOPS demonstrating successful passage beyond the hepatic flexure, preferably reaching the caecum.

A trainee who independently achieves the required stage-specific landmark might reasonably be assessed on that achievement, **even if the trainer subsequently takes over to complete the colonoscopy.**

7. What are the final completion-rate requirements?
The trainee must demonstrate an unassisted caecal intubation rate ≥90% and unassisted terminal ileal intubation rate ≥85%. In the final 30 consecutive colonoscopies in Stage 3, this effectively means ≥27/30 caecal intubations and ≥26/30 ileal intubations.

8. What does "photo documentation ≥90%" mean?
It does not mean uploading photographs from 90% of colonoscopies onto JETS. Appropriate photographic documentation should be obtained during the colonoscopy, and the paediatric colonoscopy DOPS records whether photo documentation was performed. The ≥90% certification criterion is derived from this documentation rather than requiring trainees to maintain a separate JETS image library.

Hence, take and retain appropriate landmark photographs in the clinical endoscopy reporting system and ensure photo documentation is correctly recorded on the DOPS.

Trainee does not need to upload photos on DOPS.

9. What if our endoscopy reporting system doesn't link automatically to JETS?
That does not prevent certification. The trainee still needs to record their procedural activity on JETS. JAG states that all training activity and procedure data should be

logged on the JETS ePortfolio. The clinical images themselves can remain within the local endoscopy reporting/patient record system.

10. How many DOPS do I need?
The pathway is progressive:

Stage 1 requires 5 DOPS,

Stage 2 requires 5 formative DOPS,

and the final assessment phase requires 6 formative DOPS followed by 4 summative DOPS, alongside the required reflections and procedural/KPI thresholds.

11. What happens during the final summative assessment?
There are four summative DOPS, all of which must demonstrate competence for independent practice. They must be completed within one month. JETS' general summative assessment rules require at least two assessors, at least two cases, and four observed judgments; the trainee's current primary trainer cannot act as a summative assessor.

12. What if I fail one summative DOPS?
The summative assessment is considered as a set. JETS states that if one does not meet the required standard, the four-observation summative DOPS process must be restarted.

13. Do I need to attend a course?
Yes. The pathway requires attendance at a paediatric colonoscopy basic skills course, as well as completion of the relevant e-Learning for Healthcare modules if available.

14. Once I've completed everything, am I automatically certified?
No. After completing the requirements and summative DOPS, the portfolio is reviewed and signed off by the local training lead, then submitted for national JAG/JETS review. Certification is issued after national approval.

Numbers does not always equates to competence. Reaching 150 procedures alone does not confer certification; trainees must progress through the staged competency pathway and achieve the required KPIs and DOPS.

Key messages are :-

Start DOPS early.

Don't reach 150 procedures and then discover that the staged DOPS, reflections or documentation requirements haven't been completed.

Document every case properly.

Record procedures contemporaneously on JETS, correctly identify physical assistance and completion, and ensure appropriate landmark photography is retained in the clinical endoscopy record.