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Original research

UK and Ireland Joint Advisory Group (JAG) consensus statements for training and certification in diagnostic endoscopic ultrasound (EUS)

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ABSTRACT

Background and aims International endoscopy societies vary in their approach for credentialing individuals in endoscopic ultrasound (EUS) to enable independent practice; however, there is no consensus in this or its implementation. In 2019, the Joint Advisory Group on GI Endoscopy (JAG) commissioned a working group to examine the evidence relating to this process for EUS. The aim of this was to develop evidence-based recommendations for EUS training and certification in the UK.

Methods Under the oversight of the JAG quality assurance team, a modified Delphi process was conducted which included major stakeholders from the UK and Ireland. A formal literature review was made, initial questions for study were proposed and recommendations for training and certification in EUS were formulated after a rigorous assessment using the Grading of Recommendation Assessment, Development and Evaluation tool and subjected to electronic voting to identify accepted statements. These were peer reviewed by JAG and relevant stakeholder societies before consensus on the final EUS certification pathway was achieved.

Results 39 initial questions were proposed of which 33 were deemed worthy of assessment and finally formed the key recommendations. The statements covered four key domains, such as: definition of competence (13 statements), acquisition of competence (10), assessment of competence (5) and postcertification mentorship (5). Key recommendations include: (1) minimum of 250 hands-on cases before an assessment for competency can be made, (2) attendance at the JAG basic EUS course, (3) completing a minimum of one formative direct observation of procedural skills (DOPS) every 10 cases to allow the learning curve in EUS training to be adequately studied, (4) competent performance in summative DOPS assessments and (5) a period of mentorship over a 12-month period is recommended as minimum to support and mentor new service providers.

Conclusions An evidence-based certification pathway has been commissioned by JAG to support and quality assure EUS training. This will form the basis to improve quality of training and safety standards in EUS in the UK and Ireland.

WHAT IS ALREADY KNOWN ON THIS TOPIC

- ⇒ Endoscopic ultrasound (EUS) is an advanced endoscopic procedure involving real time acquisition and interpretation of radiological images.
- ⇒ Indicators of competence include the ability to T-stage lesions, tissue acquisition through fine needle aspiration or biopsy and demonstration of image acquisition through photo documentation.
- ⇒ Development of competence is difficult and requires dedicated training in high-volume centres. There is no well established pathway for training and accrediting in EUS.

WHAT THIS STUDY ADDS

- ⇒ We have outlined a formalised framework for training and accreditation in EUS through a modified Delphi process for the first time in the UK and Ireland.
- ⇒ Accreditation criteria include having performed at least 250 procedures before an assessment of competency can take place (including 125 pancreatic cases), 75 cases involving FNA/B (>85% adequacy rate) and photo documentation in >90% cases.
- ⇒ Trainees need to be rated as “independent” by two different assessors to be signed off as competent in EUS.

INTRODUCTION

Endoscopic ultrasound (EUS) is an advanced endoscopic procedure, which combines endoscopy with acquisition and interpretation of radiological images. To achieve competency in EUS requires dedicated and supervised high-quality training. In 2011, a working party published a consensus on the future of UK EUS service provision and training.¹ Their proposed training framework included: an understanding of safe and appropriate endoscopic practice, a working knowledge of the clinical management



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HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE, OR POLICY

- ⇒ This pathway is being launched in conjunction with the Joint Advisory Group on GI Endoscopy Training System (JETS) EUS logbook.
- ⇒ There has been lack of high-quality evidence related to training in EUS. Data from JETS will provide a national picture on trainees' progress, which will inform future research on learning curves on EUS.
- ⇒ This framework will allow EUS centres to implement a structured and dedicated training pathway for advanced endoscopy trainees. This will address the unmet need for competent endosonographers in the UK and Ireland.

of those conditions for which EUS may be requested, an understanding of the strengths and weaknesses of EUS in comparison to alternative imaging modalities, an understanding of regional anatomy, the principles of medical ultrasound, an appreciation of tissue acquisition for cytopathology and histopathology assessment. However, it did not highlight specific ways in which trainees should be credentialled for independent practice.

In 2018, the European Society of Gastrointestinal Endoscopy (ESGE) published key performance indicators (KPIs) for the practice of endoscopic retrograde cholangiopancreatography (ERCP) and EUS.² Although the focus was primarily ERCP, recommendations for EUS included the identification of pathology in terms of tissue sampling and documenting EUS landmarks.

In the UK, the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) is responsible for setting standards of endoscopy training and certification.³ JAG certification is a national and standardised process in the UK whereby a trainee formally credentials for independent endoscopic practice. It has been awarded since 2011 for gastroscopy, flexible sigmoidoscopy and colonoscopy⁴ and the pathways for ERCP and gastroscopy have recently been published.^{5,6}

Following consultations with the UK Specialist Advisory Committees, an expert committee was commissioned by JAG Quality Assurance of Training Working Group to prepare for a Delphi process to work towards a certification process for diagnostic EUS.

Aims and scope

The aim of this Delphi process was to develop a robust set of recommendations which would form the framework of EUS certification for trainees within the UK. Specifically, recommendations were made in the following areas:

1. Definition of competence.
2. Acquisition of competence.
3. Assessment of competence.
4. Postcertification mentorship.

The following aspects were not included within the scope of this guideline:

- ▶ Therapeutic EUS procedures.
- ▶ Rectal EUS and endobronchial ultrasound.
- ▶ Paediatric EUS.
- ▶ Upskilling for established independent endoscopists.
- ▶ Trainees or practitioners in whom the majority of EUS training has been undertaken outside the UK or before implementation of this document.

METHODS**Guideline development**

A modified Delphi process was used to develop consensus-based recommendations on training and certification in EUS with representation from UK and Ireland training bodies, trainees and representation from key stakeholder societies which included:

- I. JAG for GI Endoscopy.
- II. British Society of Gastroenterology.
- III. UK and Ireland EUS Society (UKIEUS).
- IV. British Society of Gastrointestinal and Abdominal Radiology (BSGAR).
- V. Association of Upper Gastrointestinal Surgeons (AUGIS).
- VI. Pancreatic Society of Great Britain and Ireland.

The panel was representative of the structure of EUS services in the UK and Ireland where most EUS is performed in teaching hospitals by gastroenterologists and the invitees constituted a significant percentage of practising echoendosonographers. A cross section of 24 women and men representing both trainees and consultants independently practising in EUS were invited from the fields of radiology, surgery and gastroenterology and both district general and teaching hospitals. 19 agreed to participate in the process (online supplemental file 1). One of the participants (KS) has lead previous UK Delphi processes in colonoscopy, gastroscopy, flexible sigmoidoscopy and ERCP.⁵⁻⁸

Consensus process

The process started in December 2019. Due to the COVID-19 pandemic, meetings were conducted via teleconferencing. Problem areas for investigation were identified systematically in a two-stage process. In the first stage, problem areas were proposed among the working group leads to frame the discussion for each subsection. In the second stage, these initial proposals were circulated to the whole panel for consideration with refinements via open-ended discussions over two teleconferences. Participants were allocated to four working groups corresponding to the four domains of the guideline. Each working group was then tasked with answering the questions relevant to their section, using a Population, Intervention, Comparator and Outcome format where possible. Procedure-based outcomes were favoured over patient-based outcomes as there is very little evidence on the effect of training in EUS on patients. Literature searches were conducted by independent working groups on major databases including The Cochrane Database of Systematic Reviews, Embase and Medline. Appraisals of papers were performed independently by each subgroup. Results for each question were collated and summarised into a recommendation statement.

Recommendations were appraised using the Grading of Recommendation Assessment, Development and Evaluation framework.⁹ The level of evidence and strength of recommendation were provided for each statement. Given the paucity of evidence around EUS training, statements were permitted to receive discordant recommendations if the statements were deemed to be integral to training and certification.

Following the first round of open-ended discussion, the statements were subjected to two rounds of anonymised online voting (Typeform, Spain). Participants rated each statement on a 5-point Likert Scale (strongly disagree, disagree, neither agree nor disagree, agree and strongly agree). Eighty per cent or more agreement was the specified a priori threshold to accept a statement; ratings of 'agree' or 'strongly agree' indicated agreement. Panellists were able to submit anonymised feedback on statements. Statements that did not meet the 80% agreement

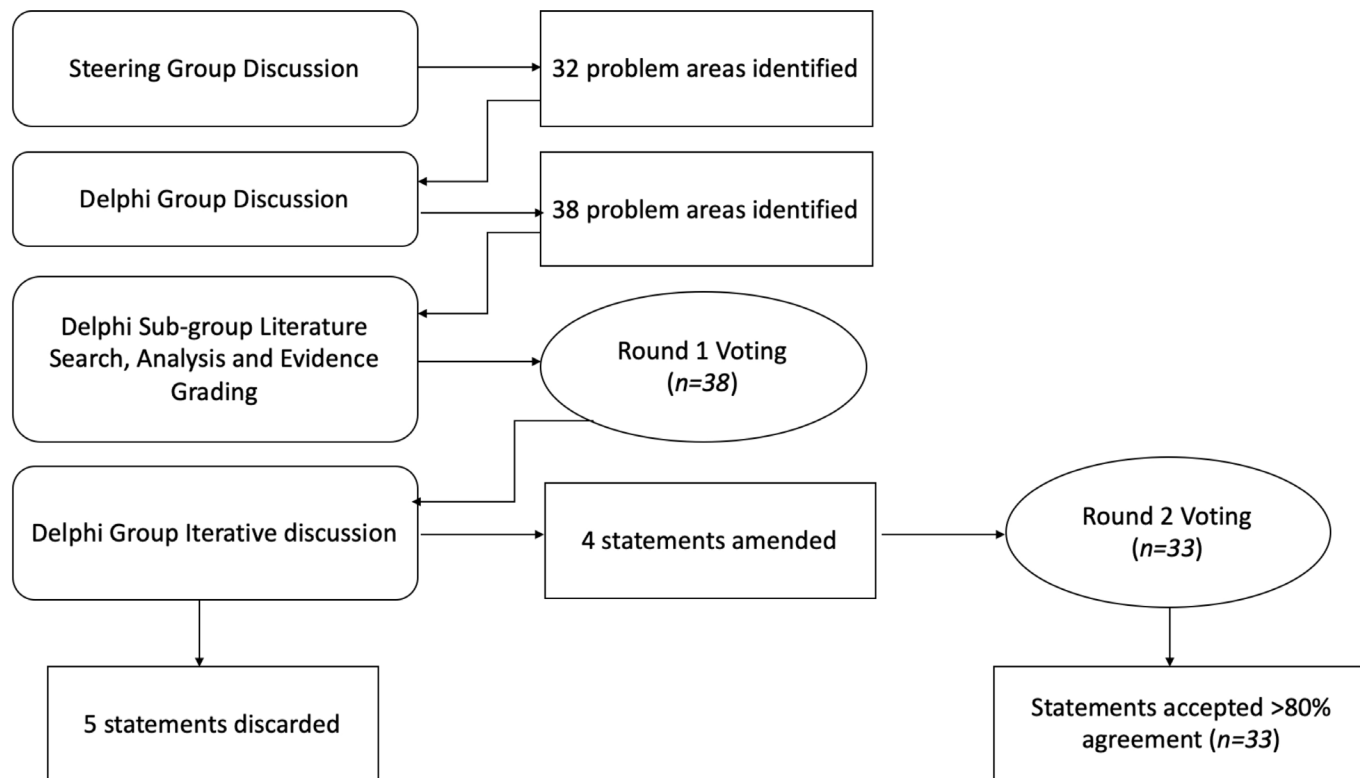


Figure 1 EUS Delphi consensus process. EUS, endoscopic ultrasound.

threshold after the first vote were subjected to iterative discussion via teleconference call and either discarded or amended for the final round of voting. Statements that did not achieve 80% agreement after the second round were discarded and the Delphi was closed. The process is outlined in [figure 1](#).

Statements were circulated to members of stakeholder societies (JAG, AUGIS, BSGAR) for analysis and appraisal with each given the opportunity of reply before statements were accepted. Statements were then included in the final EUS certification pathway ([figure 2](#)).

Recommendation statements

In total 33 recommendations statements were accepted for the following domains:

1. Definition of competence (13 statements).
2. Acquisition of competence (10 statements).
3. Assessment of competence (5 statements).
4. Postcertification mentorship (5 statements).

A full list of subsequent recommendations is highlighted in [table 1](#). The group also agreed auditable KPIs that would act as a benchmark for competent independent practice for incorporation into the JAG Endoscopy Training System (JETS) to bring EUS in line with other endoscopy accreditation in the UK

Definition of competence in performing diagnostic EUS

Diagnostic EUS is described as the imaging modality of EUS with and without tissue acquisition with fine-needle aspiration or biopsy (FNA/B) needles. (Strong recommendation, low-quality evidence).

Consensus: 89%

EUS is both an endoscopic and imaging modality and so competency in EUS can be defined as being able to perform independently both the endoscopic and imaging component of the procedure. Much of EUS involves lesion identification and

assessment so a competent operator must be able to perform tissue acquisition safely using FNA or FNB needles.¹ For a successful diagnostic EUS study without biopsy the endoscopist should be able to insert the echoendoscope to the desired level within the gastrointestinal tract dictated by the remit of the study, perform a structured station assessment and identify recognised anatomical landmarks specific to that study. (Strong recommendation, moderate quality evidence).

Consensus: 100%

There are two main types of study for diagnostic gastrointestinal EUS (1) upper gastrointestinal imaging (including the posterior mediastinum) and (2) hepatopancreaticobiliary (including retroperitoneal) EUS. Both involve the placement of the echoendoscope through the oesophagus, gastro-oesophageal junction and stomach; the latter also involves placement into the duodenal bulb and D2 in a safe manner while acquiring adequate imaging of relevant structures (online supplemental file 2). Operators may choose to practise in one or both disciplines and must be able to adequately visualise and if appropriate sample relevant structures.

The ASGE and ESGE recognise anatomical landmark identification as an important measure of quality endoscopy.¹⁰ A multicentred prospective study examining learning curves for EUS trainees incorporated landmark identification as part of competency assessment.¹¹ The extent of the EUS exam will vary depending on the clinical indication. As such, KPIs relating to procedure completion must be matched to the indication (online supplemental file 2).

EUS competence requires both cognitive and technical abilities and should be defined as the ability to independently carry out effective diagnostic procedures across a spectrum of case mix and context with acceptable safety. (Moderate recommendation, low-quality evidence)

Consensus: 89%

Proposed pathway for Training and Certification in Endoscopic Ultrasound		
Criteria 1) Personal 2) Unit	<p>PERSONAL Criteria: Commitment to EUS training and practice at consultant level JAG accreditation: - Desirable: competent in diagnostic OGD +/- with some experience in therapeutic OGD - Approval from Endoscopy Training Lead, trainer +/- Program Director</p> <p>TRAINING UNIT Criteria: - lead trainer has attended an EUS TTT course - commitment for delivery of training within a structured training programme (e.g. within a fellowship) - JAG accredited unit - initial meeting with trainee (outside of Endoscopy): introduction to the program</p>	
↓		
Training Begins		
Early Training	<p>Register with JETS e-portfolio <i>If available</i>, attend: - Induction meeting and simulation sessions - abdominal ultrasound lists - period of "hands-off" e.g. 50 cases prior to starting e.g. by use of local libraries, online resources or better still in room observation</p> <p>Book JAG BASIC EUS skills course (& Certificate)</p> <p>Begin hands-on training in an EUS training Centre</p>	<p>Procedural Key Performance Indicators - Upload hands-on procedures to JETS</p> <p>- 1 DOPS every 10 procedures</p> <p>- Minimum of 1 reflection every 50 cases</p>
Later Training	↓	<p>Regular appraisal with trainer e.g. - at no 50, 75, 100, 150, 200 and < 250</p> <p>Attendance at HPB / UGI MDT meetings Text, journal, and online digital resources</p>
	↓	
Completion of Training		
Summative Assessment	<p>Eligibility: - At least 250 "hands on" EUS cases on JETS - (including 125 cases pancreatic cases) Within last 3 months - KPIs achieved in >= 15 cases - photo documentation of anatomical ultrasound landmarks > 90% - physically unassisted > 85% cases (min 10) Case remit achieved in > 85% - 75 cases should involve EUS FNA/B of which 50 are pancreatic or other solid lesions & adequacy > 85% - Rated for independent practice in over 80% of 5 recent formative DOPS within 3 months and none requiring maximum supervision</p> <p>DOPS to include at least: - 3 cases of pancreas, bile ducts, ampulla of Vater - 1 case oesophagogastric and posterior mediastinal / lymph node assessment</p>	<p>Summative process</p> <p>- Total of 2x summative DOPS - By 2x different assessors (1 of whom is not based in current endoscopy unit)</p> <p>- Competence in all items</p>
↓		
Trainee Certified as Independent in Diagnostic Endoscopic Ultrasound		
↓		
Mentorship and Service Provision		
Post Certification as a Service Provider	<p>EUS practitioners should benefit from - arrangements for support, performance monitoring and review - Practitioners should perform > 100 cases per year, including FNA(B) - appropriate caseload selection underpinned by attending MDTs relevant to the trainee's future practice and M+M meetings</p> <p>Candidates should have the opportunity to join their local network meeting (or create one)</p> <p>Independent practice in therapeutic EUS will require specific training</p>	<p>Period of Post - Certification Mentorship - Mentorship may take place outside their respective unit</p> <p>- Introduction meeting outside of the unit thus, setting expectations - then 3 monthly progress reviews - Initial 1-year time frame as a minimum - Final sign off meeting (informal agreements for further mentorship however can be made)</p>

Figure 2 JAG EUS certification pathway. DOPS, direct observation of procedural skills; EUS, endoscopic ultrasound; FNA/B, fine-needle aspirations/ biopsies; HPB, hepatobiliary; JAG, endoscopic ultrasound; JETS, JAG Endoscopy Training System; KPI, multidisciplinary team; MDT, multidisciplinary team; M+M, morbidity and mortality; OGD, oesophagogastrroduodenoscopy; TTT, train the trainers.

Table 1 Summary of recommendations for training and certification in EUS

1.1	Diagnostic EUS is described as the imaging modality of EUS with and without tissue acquisition with fine-needle aspiration or fine-needle biopsy needles.
1.2	For a successful diagnostic EUS study without biopsy the endoscopist should be able to insert the echoendoscope to the desired level within the gastrointestinal tract dictated by the remit of the study, perform a structured station assessment and identify recognised anatomical landmarks specific to that study (online supplemental file 2).
1.3	EUS competence requires both cognitive and technical abilities and should be defined as the ability to independently carry out effective diagnostic procedures across a spectrum of case mix and context with acceptable safety.
1.4	The endoscopist must be able to effectively identify and precisely describe the gastrointestinal wall layers and peri-lesional structures to demonstrate the likely origin of a submucosal mass or for T-stage evaluation.
1.5	Comprehensive understanding of the anatomical landmarks is mandatory for safe EUS guided tissue acquisition including for non-gastrointestinal tumours (eg, lung cancer, sarcoma) where understanding of relevant posterior mediastinal anatomical landmarks is necessary.
1.6	It is necessary to have a working knowledge of ultrasound, the ultrasound console, radiological descriptions of normal anatomy and radiological descriptions of pathological changes. The endoscopist must be able to acquire, optimise and capture ultrasound images.
1.7	Tissue acquisition: It is desirable that 75 EUS FNA/FNB (including 50 pancreatic lesions) are performed during training and the endosonographer will be required to demonstrate proficiency in the use of FNA/FNB EUS needles.
1.8	When performing tissue acquisition the endoscopist should demonstrate the ability to document sampled area, needle sizes used, type of needle along with no of passes for audit and safety purposes. A tissue adequacy rate of 85% should be the aim for solid pancreas masses.
1.9	An overall 30-day case complication rate of <5% of the EUS caseload is expected.
1.10	The endoscopist must demonstrate ability to write a comprehensive, structured, and descriptive EUS report with a final provisional diagnosis. All stations and the abnormality should be reported in detail including size, location, echogenicity, TNM staging (if appropriate) as well as peri- and postprocedural complications.
1.11	The endoscopist is expected to photo-document ultrasonographic anatomical landmarks relevant to the focus of the examination (see online supplemental file 4) in >90% of procedures and upload to PACS or appropriate software.
1.12	The endoscopist should photo-document ultrasonographic and endoscopic images of pathology identified using appropriate tools including Doppler, callipers to measure size and needle placement to upload to a picture archiving and communication system (PACS) or appropriate software.
1.13	The endoscopist demonstrates a professional attitude towards procedural safety and patient care including the practice of endoscopic non-technical skills of EUS (ie, communication skills, situational awareness, leadership and judgement).
2.1	JAG accreditation in gastroscopy is desirable. The endoscopist should be sufficiently competent to safely insert a gastroscope to D2 independently.
2.2	Trainees should demonstrate their desire and commitment to perform independent practice in EUS at consultant level.
2.3	For EUS certification, UK trainees are required to attend a JAG accredited basic EUS skills course, ideally in the early stages of their EUS training.
2.4	Trainees are recommended to use digital resources and attend live endoscopy courses and conferences to become familiar with EUS techniques and accessories.
2.5	Trainees are required to show evidence of attendance at multidisciplinary meetings
2.6	Training should be delivered at specific levels to include: A. Assessment of indications and potential complications for the procedure, individualised consent and review of imaging immediately prior to each case. B. Trainees should spend a period familiarising themselves with image acquisition and interpretation prior to echoendoscope handling. This should be a combination of observing EUS cases and spending time with ultrasonographers. C. Formal hands-on training should use the EUS Train the Trainers (TTT) training ladder. D. Postprocedure care and accurate report writing should also be a part of training. Trainees should audit their own practice during the training process and document any complications with evidence of reflection.
2.7	Training in ultrasound should be an essential facet of acquiring competence: A. Focused sessions on the use of the ultrasound console. B. Use of appropriate terminology, image optimisation and acquisition, accurate labelling, use of Doppler, etc and appropriate key images to capture. C. Contrast-enhanced ultrasound and elastography (can be acquired postcertification).
2.8	Trainers delivering training in EUS should have undertaken an endoscopy specific TTT course (preferably in EUS).
2.9	Trainers should ensure that their trainees are empowered to be able to give honest and critical feedback on their training. This is generic to all forms of endoscopy training and is a JAG requirement.
2.10	All trainees should have evidence of experience of a minimum of 250 EUS cases prior to assessment for certification.
3.1	Formative EUS DOPS assessments should be performed at least every 10 training procedures to track progression and provide objective evidence of skills acquisition and targeted feedback. EUS DOPS should include ultrasound imaging and endoscopy, but also previous cross-sectional image evaluation, fulfilment of procedure indication and non-technical skills.
3.2	Trainee should preferably log all training procedures onto the JETS e-portfolio.
3.3	Trainees must demonstrate the following KPIs to be eligible for summative assessment for certification in diagnostic EUS with/without tissue acquisition A. 'Competent for independent practice' overall in formative DOPS in 80% cases in last 3 months (minimum of 10 cases). B. Cases should include at least: i. One examination including oesophagogastric assessment, posterior mediastinal and lymph node assessment. ii. Three examinations including assessment of the whole pancreas plus bile duct including the ampulla of Vater. FNA/B diagnostic adequacy >85% of cases in last 3 months (minimum of 10 cases).
3.4	Formative EUS DOPS and KPI should be used in conjunction with other supporting certification criteria including: A. Attending EUS Basic Skills course. B. Completion of a minimum of 250 cases before summative assessment including 125 pancreatic assessments.
3.5	For successful completion of the Summative DOPS assessment, the trainee should be rated as 'ready for independent practice' in all items within 2 DOPS on predefined cases, by two different assessors: one of whom is not based at their current endoscopy unit.
4.1	Newly certified EUS practitioners should have a minimum period of mentorship lasting 1 year.
4.2	A JAG/UKIEUS defined list of mentors who can be approached by a mentee is desirable.

Continued

Table 1 Continued

4.3	EUS practitioners should perform 100 cases per year, of an adequate case mix including FNA. They should regularly review their performance via audit of KPI, presentation at M+M meetings, 360 assessments and via the annual appraisal system.
4.4	In single operator practices, EUS practitioners should have the opportunity the join local networks and if they do not exist, they should make efforts to form them.
4.5	Independent practice in therapeutic EUS will require specific training.

DOPS, direct observation of procedural skills; EUS, endoscopic ultrasound; FNA/B, fine-needle aspirations/biopsies; JETS, JAG Endoscopy Training System; KPI, key performance indicator; UKIEUS, UK and Ireland EUS Society.

Competency is a complex set of behaviours built on the components of knowledge, skills, attitudes and competence as 'personal ability'.¹² To achieve competency an operator must develop both the technical ability to perform EUS (eg, scope handling) and develop their knowledge base of ultrasound imaging to interpret real time images for diagnosis and act on their findings.

The endoscopist must be able to effectively identify and precisely describe the gastrointestinal wall layers and perilesional structures to demonstrate the likely origin of a subepithelial mass or for T-stage evaluation and lymph node evaluation. (Strong recommendation, low-quality evidence)

Consensus: 100%

The ability to identify the layer of origin of subepithelial lesions is crucial to determining the likely underlying diagnosis and involvement of surrounding structures. T-staging has been studied and validated as a surrogate marker of competent performance.¹³

A comprehensive understanding of the anatomical landmarks is mandatory for safe EUS-guided tissue acquisition for gastrointestinal lesions and non-gastrointestinal tumours (eg, lung cancer, sarcoma) where understanding of relevant posterior mediastinal and retroperitoneal anatomical landmarks is necessary. (Strong recommendation, low-quality evidence)

Consensus: 95%

Many authors agree that the rationale in understanding anatomical landmarks is key to interpreting EUS imaging.^{2,14-16} Moreover, a variety of authorities have highlighted the need for a comprehensive learning tool for trainees to be able to assess all aspects of training.¹⁷ Tissue acquisition is undertaken frequently as part of routine EUS practice.¹⁸ Trainees must demonstrate an understanding of landmarks to be able to safely undertake tissue acquisition in this context.

It is necessary to have a working knowledge of ultrasound, the ultrasound console, radiological descriptions of normal anatomy and pathological changes. The endoscopist must be able to acquire, optimise, capture and label ultrasound images. (Strong recommendation, low-quality evidence).

Consensus: 95%

The acquisition and description of images in EUS should be considered in the same way as conventional ultrasound. It is beyond the scope of this Delphi process to consider competency assessment in clinical ultrasound.¹⁹ For endosonographers wishing to demonstrate minimum knowledge of ultrasound the following knowledge base is recommended:

- ▶ Basic ultrasound physics.
- ▶ Operation of machine control (eg, depth, zoom, gain, focus, image capture).
- ▶ Image optimisation.
- ▶ Relevant normal and abnormal sonography anatomy and physiology.
- ▶ Specific application and limitations of ultrasound applied within EUS.

The Royal College of Radiologists recommend guidelines for the provision of an ultrasound service.²⁰ Their standards

for imaging interpretation outline the following framework for examination²¹:

- ▶ Remit of the study.
- ▶ Normal findings.
- ▶ Unequivocal abnormal findings, both anticipated and unanticipated.
- ▶ Findings that may be normal (including their anatomical variants) or abnormal
- ▶ Relevant negatives.

Abnormal findings must be analysed for relevant imaging characteristics such as shape, definition and contour, enhancement pattern, and echogenicity to discern whether the findings fulfil a pathological process or may represent a normal variant such as age-related change. Non-radiology trainees should consider shadowing radiologists performing transabdominal ultrasound to familiarise themselves with image acquisition techniques, radiological lexicon and, crucially, reporting.

The Delphi group were unanimous in recommending trainees from a non-radiological background undertake a period of attendance at ultrasound and cross-sectional imaging lists with a radiologist to gain appreciation of indications, terminology and language of reporting of scans, as well as commencing the early phase of EUS training with a 'hands-off' approach to familiarise themselves with ultrasound image acquisition and interpretation. Tissue acquisition: It is desirable that 75 EUS FNA/FNB (including 50 pancreatic lesions) are performed during training and the endosonographer will be required to demonstrate proficiency in the use of FNA/FNB EUS needles (Strong recommendation, low-quality evidence).

Consensus: 100%

There are limited, poor-quality, retrospective studies that suggest EUS-FNA/B training is safe²² and that formal training results in an increased diagnostic sensitivity in pancreatic solid lesion sampling.²³ In one study, diagnostic accuracy >80% was achieved after 250 procedures; therefore, the learning curve may be longer and require a considerable number of procedures to achieve high diagnostic accuracy (in the absence of Rapid Onsite Evaluation).²⁴ While the evidence suggests that competency in sampling the pancreas is achieved around this mark, the group agreed that a lifetime procedure account of 75 reflected the additional experience required in sampling non-pancreatic lesions. In training centres with a low volume of pancreatic pathology, it is reasonable for case numbers to be derived from a mix of solid lesions including gastrointestinal stromal tumours (GISTs). There is robust evidence that FNB outperforms FNA in terms of diagnostic accuracy and tissue core rate and should be first line for solid lesions.²⁵⁻²⁸

When performing tissue acquisition the endoscopist should demonstrate the ability to document sampled area, needle sizes used, type of needle along with number of passes for audit and safety purposes. A tissue adequacy rate of 85% should be the aim for solid pancreas masses. (Strong recommendation, moderate quality evidence).

Consensus: 100%

Tissue adequacy is defined as obtaining sufficient tissue to allow an accurate diagnosis, that is, the percentage of cases in which a specific histological diagnosis was made (eg, benign or malignant). 'Inadequate' samples should not be excluded from calculation of an endosonographer's KPIs and samples that are 'suspicious' but not definite for a diagnosis should be considered inadequate.

An overall 30-day case complication rate of <5% of the EUS caseload is expected. (Strong recommendation, moderate quality evidence).

Consensus: 100%

While EUS is not without risk, it is generally regarded as a relatively safe procedure. Rates of complication for FNA are low. In a multicentre retrospective observational study in tertiary referral centres in Japan focused on adverse events with EUS-FNA the incidence was 1.7% in a cohort of 13 566 cases.²⁹ Multiple studies have reported complications rate of between 1% and 3%.^{30 31} Aspiration of pancreatic cystic lesions seems to have a higher complication rate of 6%³² although most are mild. The ESGE technical guideline encompassing a systematic review of literature related to FNA reported a morbidity between 0% and 2.5%.³³ Based on this, we have recommended a complication rate of <5% but with an aspiration of being <3%.

The endoscopist must demonstrate ability to write a comprehensive, structured and descriptive EUS report with a final provisional diagnosis. All stations and the abnormality should be reported in detail including size, location, echogenicity, TNM staging (if appropriate) as well as periprocedural and postprocedural complications and recommendations. (Strong recommendation, low-quality evidence).

Consensus: 95%

The purpose of a report is to communicate an answer to the clinical question posed in a way the referrer will understand and be able to action if appropriate.³⁴ The operator should use appropriate radiological terminology and we suggest adhering to the Royal College of Radiologists quality standards, which recommend a report is structured as follows²¹:

- ▶ Clinical details, review of previous imaging, remit of the EUS study.
- ▶ A description of the findings and correlation with previous findings.
- ▶ A conclusion or summary of the key findings in the clinical context.
- ▶ Advice on the next step of management (when appropriate).

The endoscopist is expected to photo-document ultrasonographic anatomical landmarks relevant to the focus of the examination (online supplemental file 4) in >90% of procedures and upload to a picture archiving communication system (PACS) or appropriate software (weak recommendation, low-quality evidence).

Consensus: 84%

EUS practice should be standardised with ultrasound to be able to save a representative range of images to PACS software to provide a record of the examination to allow for case review and audit purposes.²⁰ Photo documentation of landmarks dependent on the indication of the examination form part of the KPIs (outlined in online supplemental file 2).

The endoscopist should photo document ultrasonographic and endoscopic images of pathology identified using appropriate tools including Doppler, callipers to measure size and needle placement to upload to PACS or appropriate software. (weak recommendation, low-quality evidence).

Consensus: 95%

Systematic documentation of the EUS procedure through image acquisition uploaded on to an image sharing portal such as PACS allows multidisciplinary teams (MDTs) and other clinically interested parties to easily review a case and demonstrates the operator is competent in what they are examining.

The endoscopist demonstrates a professional attitude towards procedural safety and patient care including the practice of endoscopic non-technical skills (ENTS) of EUS (ie, communication skills, situational awareness, leadership and judgement). (Strong recommendation, low-quality evidence).

Consensus: 100%

The evidence in this area is limited predominantly to non-controlled surveys of participants undertaking non-technical skills training in the form of simulation who demonstrate increased self-reported confidence in performing non-technical skills tasks.³⁵ One blinded randomised control trial (RCT) did demonstrate a simulation-based curriculum (including ENTS) resulted in endoscopists performing superiorly on colonoscopies assessed using the JAG direct observation of procedural skills (DOPS).³⁶ The same group published a further RCT in 2020, which demonstrated focused non-technical skills training to novice trainees in colonoscopy improved the clinical performance of their colonoscopies.

Acquisition of competence in EUS

JAG accreditation in gastroscopy is desirable. The endoscopist should be sufficiently competent to safely insert a gastroscope to D2 independently. (Strong recommendation, very low-quality evidence).

Consensus: 95%

Trainees commencing EUS training should be competent at upper GI endoscopy and should be able to pass the gastroscope safely to D2. The group agreed that formal JAG accreditation is desirable, however, is not mandated as this may prejudice non-gastroenterology trainees wishing to embark on an EUS training programme. ESGE also acknowledges that trainees should be competent in gastroscopy before undertaking ERCP or EUS in line with their previously published quality standards.^{14 37} It is likely that further scope-handling training will be required due to the differences in using oblique viewing echoendoscopes.

Trainees should demonstrate their desire and commitment to perform independent practice in EUS at consultant level. (Strong recommendation, low-quality evidence).

Consensus: 90%

The considerable commitment on trainee and trainer to achieve trainee competence in EUS is such that forward planning and workforce management should be taken into consideration to ensure trainees' future careers will include the practice of EUS.

For EUS certification, UK trainees are required to attend a JAG accredited basic EUS skills course, ideally in the early stages of their EUS training. (Strong recommendation, low-quality evidence).

Consensus: 84%

An essential part of EUS training is the attendance at intensive skills courses.³⁸ Attendance at basic skills courses is already mandatory for certification in upper and lower GI endoscopy and ERCP.

Trainees are recommended to use digital resources and attend live endoscopy courses and conferences to become familiar with EUS techniques and accessories. (Strong recommendation, low-quality evidence).

Consensus: 100%

Theoretical knowledge acquired in addition to hands-on training can be acquired from lectures, textbooks, online seminars and websites.³⁵ This further complements the training process in a safe and effective manner.

Trainees are required to show evidence of attendance at Multi-disciplinary Meetings. (Strong recommendation, very low-quality evidence).

Consensus: 100%

This is an essential part of the learning process. Attendance at both benign and cancer MDTs is crucial to understand the rationale for the test and the information desired by the referrer. It is also an opportunity to be exposed to cross-sectional imaging modalities that may aid the EUS examination.

Training should be delivered at specific levels to include:

- Assessment of indications and potential complications for the procedure, individualised consent and review of imaging immediately prior to each case.
- Trainees should spend a period familiarising themselves with image acquisition and interpretation prior to echo-endoscope handling. This should be a combination of observing EUS cases and spending time with ultrasonographers.
- Formal hands-on training should use the EUS train the trainers (TTT) training ladder.
- Post procedure care and accurate report writing should also be a part of training.

Trainees should audit their own practice during the training process and document any complications with evidence of reflection. (Strong recommendation, low-quality evidence)

Consensus: 89%

This highlights the importance of a safe and considered approach before, during and after each procedure. A standardised method to training, as taught on the EUS TTT course, will benefit both trainer and trainee (online supplemental file 3). Reviewing imaging prior to procedures is a key component of training that trainers should aim to promote through the development of a dedicated archive of cases for learning and assessment.

Training in ultrasound should be an essential facet of acquiring competence:

- The trainee requires focused sessions on the use of the ultrasound console.
- Use of appropriate terminology, image optimisation and acquisition, accurate labelling, use of Doppler, etc and appropriate key images to capture.
- Contrast-enhanced US and elastography can be acquired postcertification. (Strong recommendation, low-quality evidence)

Consensus: 89%

Safe endoscope handling and ultrasound image acquisition and developing a skill set for the interpretation of ultrasound images for diagnosis are essential features to competent EUS practice and should be embedded in daily teaching.

Trainers delivering training in EUS should have undertaken an endoscopy specific TTT course (preferably in EUS). (Strong recommendation, very low-quality evidence)

Consensus: 95%

EUS trainers should have completed a TTT course, preferably in EUS to standardise key components of the training process. The EUS TTT course covers the principles of adult learning, adding to the trainer's skillset in endoscopic and sonographic teaching to provide a safe and comprehensive training experience.

Trainers should ensure that their trainees are empowered to be able to give honest and critical feedback on their training. This is

generic to all forms of endoscopy training and is a JAG requirement. (Strong recommendation, very low-quality evidence)

Consensus: 100%

Despite the introduction of Direct Observation of Trainer Skills feedback by JAG, a recent survey of UK trainees demonstrated only 57% trainees felt able to give honest feedback to their trainer.³⁹ Given the complexity of teaching EUS, trainers should seek feedback and engender a collaborative training environment.

All trainees should have evidence of a lifetime 'hands-on' experience of a minimum of 250 EUS cases prior to assessment for certification. (Strong recommendation, moderate-quality evidence)

Consensus: 100%

The previous British expert consensus on EUS training recommended the following threshold numbers before assessment of competency: oesophagus, stomach or rectum—80; subepithelial lesions—20; pancreatobiliary—150 (at least half of which are likely pancreatic cancer).¹ A systematic review examined 8 studies assessing attainment of competency in EUS and encompassed 28 trainees and 7051 EUS procedures.⁴⁰ Three studies examined T staging (competency achieved in 65–231 procedures), 3 studies assessed EUS-FNA (competency achieved by 30–40 procedures) and 2 studies assessed comprehensive competency. Only 4 of 17 trainees reached competency by 225 to 295 EUS procedures. Further evidence that suggests a significant caseload of hands-on training is required prior to competency assessment highlighted the median number of EUS performed was 300 by which 82.3% trainees had achieved overall competence.⁴¹

Assessment of competence in EUS

Formative EUS DOPS assessments should be performed at least every 10 training procedures to track progression and provide objective evidence of skills acquisition and targeted feedback. EUS DOPS should include ultrasound imaging and endoscopy, but also previous cross-sectional image evaluation, fulfilment of procedure indication and non-technical skills. (Strong recommendation, low-quality evidence)

Consensus: 95%

Formative EUS assessments are used to complete endoscopic training in the UK.^{42–44} The use of specific formative EUS DOPS assessments grouped to enable assessment of specific technical and non-technical endoscopic skills are to be incorporated within the JETS e-portfolio.³⁹ The TEESAT assessment tool has been validated in North American fellowship programmes for EUS.^{10 11 45} This is not currently supported on the JETS eportfolio although four similar levels of outcomes reflect the amount of supervision required (maximal to none). Increasing the frequency of formative DOPS assessment increases the reliability of competency estimation⁴⁶ and has been identified as an independent predictor of competence.⁴²

Trainee should preferably log all training procedures onto the JETS e-portfolio. (Strong recommendation, low-quality evidence)

Consensus: 95%

The JETS e-portfolio is recognised by all UK endoscopy trainees and trainers. Validity is supported from other training modalities.⁴⁷ The JETS system enables the formulation of unassisted KPIs, which are embedded into EUS certification criteria. Evidence for a similar model using ERCP exists using the Rotterdam self-assessment ERCP form.^{48 49}

Trainees must demonstrate the following KPIs to be eligible for summative assessment for certification in diagnostic EUS±tissue acquisition:

- a. 'Competent for independent practice' overall on formative DOPS in 80% of cases in the last 3 months (minimum 10 examinations).
- b. Cases should include documented images and include at least:
 - 1 Examination including:
 - ▶ Oesophagogastric assessment.
 - ▶ Posterior mediastinum/lymph node assessment.
 - 3 examinations including:
 - ▶ Full pancreas assessment.
 - ▶ Bile duct examination (including ampulla of Vater).
- c. Tissue acquisition with FNA/B diagnostic adequacy >85% of cases in the last 3 months (minimum 10 cases). (Strong recommendation, low quality evidence)

Consensus: 100%

KPI targets for competent independent practice should be measured by objective formative DOPS (online supplemental file 4). Increasing the frequency of formative DOPS assessment increases the reliability of competency.⁴⁶ A prospective, multi-centre US study using a similar outcome (TEESAT) to the UK formative (DOPS) form showed that at the conclusion of EUS training programme 82% of trainees achieved technical independent competence and 76% achieved cognitive independent competence in EUS.¹¹ Therefore, a similar level of independent practice achievement should be recorded in a significant number⁴⁸ to achieve a high chance of competence.

As the influence of EUS-FNA/B is significant this must be included as a KPI. The percentage of patients with a tissue sample allowing an accurate diagnosis of solid lesions should be recorded. The frequency of successful EUS-FNB of a solid lesion has been shown to be 92%–98% in multiple clinical trials^{25 50–53}; therefore, we would expect this level to be at least 85% (minimum standard in line with ESGE) and a target standard of 90% postcertification.

Formative EUS DOPS and KPI should be used in conjunction with other supporting certification criteria including

- a. EUS basic skills course.
- b. Evidence of at least 250 procedure entries on JETs including 125 cases with pancreatic assessment (Strong recommendation, low-quality evidence)

Consensus: 100%

A basic skills course is recommended to enable training pathway structure and development. Formative DOPS assessments are used to objectively evaluate competency development during training.¹¹ Therefore, we believe this number of procedures is required to achieve a high chance of competence for independent practice and achieve success at summative assessment.

For successful completion of the summative DOPS assessment, the trainee should be rated as 'ready for independent practice' in all items within 2 DOPS on predefined cases, by two different assessors: one of whom is not based at their current endoscopy unit. (Weak recommendation, low-quality evidence)

Consensus: 89%

Summative assessment is part of the JAG certification process and ensures objective competence assessment prior to certification.⁴ Given the complexity of EUS and small number of agreed KPIs, to reduce bias we recommend that trainees should perform a total of 2 summative EUS DOPS and be rated as 'ready for independent practice' in all items by two separate assessors, of which one of these assessors should not be a current trainer

based at the trainee's unit. We recognise the relative paucity of endosonographers around the UK and Ireland so JAG will be working to compile a national list of assessors to facilitate this process.

The summative assessment cases should take place at an endoscopy unit chosen by the trainee (usually their current or recent training unit). At least one of the assessors should have attended an EUS TTT course.

Postcertification mentorship

Newly certified EUS practitioners should have a minimum period of mentorship lasting 1 year. (Strong recommendation, very low evidence)

Consensus: 89%

Performance of EUS continues to improve after certification during the early part of independent practice before aspirational standards may be reached, it follows therefore that there should be provision for mentorship and performance review for recently certified EUS practitioners.^{54–56}

Opportunities for continuing professional development should be encouraged including upskilling courses and visiting regional tertiary units. Both mentor and mentee should have time to invest in the relationship, ideally with protected time for regular meetings. Coaching and mentoring has been defined as 'learning relationships which help people to take charge of their own development, to release their potential and to achieve results which they value'.⁵⁷

Although a universal understanding of mentorship has been historically elusive, it is now increasingly recognised in healthcare.^{58–62} 'EUS mentorship' may be defined as the process by which an experienced colleague who performs high-quality EUS engages with a new colleague to foster their development and expertise in EUS. A period of at least 1 year is suggested to enable enough time to support and nurture a practitioner into one who can provide a high-quality EUS service.

A JAG/UKIEUS defined list of mentors who can be approached by a mentee is desirable. (Strong recommendation, low evidence)

Consensus: 95%

A JAG/UKIEUS list of mentors who have undertaken a mentorship qualification that can be approached by the mentee and their respective Trust is desirable. Mentors themselves should be expert in their field: consciously competent in EUS and in teaching EUS. Additional training may be required to develop specific mentorship expertise. It is strongly recommended mentors have completed the JAG EUS 'TTT' course.

EUS practitioners should perform 100 cases per year, of an adequate case mix including FNA/B. They should regularly review their performance via audit of KPI, presentation at morbidity and mortality (M&M) meetings, 360 assessments and via the annual appraisal system. (Strong recommendation, very low evidence)

Consensus: 95%

Clinicians who have recently certified in EUS should have the opportunity to practise in a wide range of subspecialty areas. Caseload selection through attendance at weekly MDT meetings is vital to this. All EUS cases should be logged to enable continuous audit of KPIs and to recognise post-EUS complications. In the medium-term some of this data will be captured through the National Endoscopy Database (NED) but clinicians should interrogate their EUS reporting tools to provide personal and unit results to be presented at regular audit meetings.

In single operator practices, EUS practitioners should have the opportunity to join local networks and if they do not exist, they should make efforts to form them. (Strong recommendation, very low evidence)

Consensus: 89%

Single-handed EUS practitioners should aim to join local networks to allow for coaching and help with service development and joint audit of results. If such networks do not exist, then the new EUS practitioner should make efforts to form them where possible.

Independent practice in therapeutic EUS will require specific training. (Strong recommendation, very low evidence)

Consensus: 100%

Therapeutic EUS procedures are complex with a significantly higher complication rate. Therefore, robust and safe patient pathways need to be established with MDT input and careful governance of outcomes. Although out of the scope of this document, before undertaking therapeutic EUS, clinicians should undergo a period of additional training (eg, via a preceptorship) with further mentorship to follow. It is desirable that endosonographers embarking on therapeutic EUS should have basic ERCP skills. Due to the rapidly expanding number of therapeutic EUS interventions available, the Delphi group felt that trying to outline a training and accreditation therapeutic pathway in addition to the diagnostic pathway was too broad a scope. However, we recognise the need for therapeutic accreditation and this will be the subject of a future Delphi process.

DISCUSSION

EUS is a technically demanding modality which involves a steep learning curve. While there is an increasing number of therapeutic procedures achievable with EUS guidance there is, prior to this, an imperative to ensure conscious competence in echoendoscope handling and accurate interpretation of ultrasound images. Moreover, during the procedure, the endosonographer must demonstrate good non-technical skills, perform tissue acquisition correctly, generate a report that answers the clinical question and always ensure patient safety.

Defining operator competency for EUS in comparison to, for example, ERCP or colonoscopy has been elusive. The latter studies have recognised quality performance indicators that can be assessed before, during and after the procedure while EUS historically does not. This partly relates to the varied remits of EUS examination that can be undertaken, a lack of consensus on judging competency of ultrasound imaging for trainee gastroenterologists, and a focus on FNA/B sampling adequacy and diagnostic rates that can only be evaluated retrospectively.^{14 41}

This Delphi group has assessed a comprehensive number of published scientific papers to address key questions of diagnostic EUS training reaching consensus on defining competence, the pathway to achieve this and its assessment to allow trainees to credential for independent practice. Like ERCP, the group has also examined the rationale for mentoring newly qualified practitioners.⁵ To reflect current practice and most service providers there is an emphasis on linear echoendosonography.

The CREDES framework is a tool that has been published for assessing the quality of Delphi processes with a focus on four aspects: rationale, planning and design, study conduct and reporting.⁵⁴ By most of the 16 criteria outlined in this framework, our methodology was robust but there were

a few potential limitations. The size of the Delphi group (n=19) could leave our conclusions open to potential bias. However, the number of practising endosonographers in the UK is low (the last recorded estimate was 95 in 2011)¹ and thus we believe the group is reflective of current practitioners of EUS in the UK and Ireland. We recognise that bias may be evident in statements receiving strong recommendations with weak evidence but again there is a paucity of high-quality research in the field, with a significant proportion of studies the product of one group.^{10 11 13 41 55} As such, we have allowed discordantly high strength recommendations when the group determined a statement was integral to training or certification. While this leaves recommendations open to criticism it is our expectation that by setting these standards, high-quality research can be undertaken in the future to corroborate or refute our recommendations. A further limitation is that stability of responses was not measured between rounds potentially masking bias as statements were accepted a priori after the first round of voting once they crossed the 80% threshold. Finally, given the group of invited participants were from the UK and Ireland results may not be relevant to other international centres of EUS training.

While the Delphi group advocates a period of attendance at ultrasound and cross-sectional abdominal and thoracic imaging lists in addition to a period of 'hands off' observation there is currently no evidence base on which to base a recommendation. However, given the vast majority of practising endosonographers in the UK will be gastroenterologists it was felt a period of familiarisation with imaging modalities was important. While we have recommended at least 250 'hands on' procedures be performed prior to an assessment of competency, based on the best available evidence,⁴¹ we recognise there is a spectrum of ability with different case numbers required to reach independent practice. Following the publication of this pathway, the opportunities presented by the mandated use of the JETS to record procedures represent an exciting research opportunity to prospectively track learning curves at a national level.

The ASGE set out their core curriculum for EUS training in 2020⁶³ although through expert consensus rather than a formal Delphi process. In it, they outline a broad brush approach to the structure of EUS training and the principles of what competence looks like but stop short of prescriptive KPIs. ASGE published their combined EUS and ERCP curriculum in 2021.¹⁴ Given the limited literature on the issue, they have understandably alighted on similar KPIs for competence as our own Delphi process (procedure volume of >250 cases (75 FNA/FNBs), satisfactory visualisation of key anatomical landmarks in ≥90% of cases, and an FNA/FNB accuracy rate of ≥85%). They outline endosonographers 'should undergo formal summative assessment prior to completion of independent practice' without specifying what this entails. The strength of our study over both the ASGE and ASGE documents is to have produced an exhaustive training and assessment structure with auditable KPIs. Trainees and trainers alike will be able to use this framework to design their training experiences and standardise credentialing of new endosonographers on a national scale.

We propose a syllabus divided into three domains: (1) 'early novice' (0–75 cases), (2) 'intermediate' (76–150 cases) and (3) 'advanced' (151–250 cases). The syllabus (see online supplemental file 3) highlights defined categories to allow trainers and trainees to focus on learning milestones. The categories comprise: background knowledge, scope handling,

use of the ultrasound console, the study of EUS anatomy for normal and pathological lesions, the interpretation of ultrasound images and tissue acquisition. These culminate in the 'complete EUS procedure'. In advanced training, the focus increases on ENTs.

There are no published studies on the best way to teach the interpretation of real time continuous imaging in EUS. Trainers focus primarily on teaching specific anatomical landmarks or 'stations'. In online supplemental files, the stations are discussed in detail. For each station, there is a summary list of key images recommended for the trainee to develop competency in recognising. Domains 1 and 2 focus primarily on a structured approach to anatomy teaching; domain 3 (advanced) focuses on the ability to interpret real-time continuous imaging: that is, being able to 'follow the anatomy'. The Delphi group recommends all EUS procedures provide captured images to be stored on a PACS system; EUS is an imaging modality and as such should be in line with all imaging modalities. We envisage recordings of small video loops on PACS to become routinely available for the respective MDTs.

Historically, EUS training programmes have relied on set procedure numbers to attain competence.^{1 2 64} Wani *et al* have advocated for standardisation of assessment to individualise the number of procedures required for training.^{10 55} Although the widespread practice of trainers is to focus on procedure volume,⁵⁵ the direction of travel is towards competency-based training. Competency based fellowships have been shown to result in trainees meeting quality indicators through their first year of independent practice. A 2016 systematic review of structured assessment of EUS competencies identified technical skills including pancreatic solid mass T-staging, EUS-guided FNA (EUS-FNA) procedure time, number of EUS FNA passes and puncture precision for EUS that could form the basis of competency based accreditation.⁶⁵ An endoscopy trainers' course, such as the JAG 'TTT' in EUS, can highlight the importance of the EUS curriculum, improve the different techniques of performance enhancing feedback and teach how to make objective and measurable assessments of trainees.⁶⁶

Following the GMC commissioned 'Shape of Training' review the training of UK physicians is undergoing considerable change due to the implementation of shorter training times in gastroenterology from 5 to 4 years which also impacts training in endoscopy (68). Competency in specialties such as ERCP and EUS therefore may require post-CCT fellowships.

There are opportunities for future research using the competency framework outlined in this document. The JETS ePortfolio has been instrumental in driving quality standardisation across the UK in endoscopic practice for OGD, flexible sigmoidoscopy and colonoscopy. At the time of writing, JAG is engaging with stakeholders in the development of a robust JETS ePortfolio for EUS and the KPIs agreed by this working group will inform the accreditation through the upcoming JETS update. An EUS DOPS for assessment of competence has been proposed as part of this Delphi process. Performing a prospective study of the use of national JETS data learning curves to more accurately assess how trainees achieve EUS competency in the UK will further our knowledge. An appreciation of key interventions to 'accelerate' trainees up the learning curve including 'early novice'-stage exposure to diagnostic abdominal ultrasound lists, the use of intensive fellowships, simulation and virtual reality will be important.

CONCLUSIONS

This document attempts to be specific in the training requirements desired for service providers to undertake high-quality EUS examinations. This will enable training bodies to ensure adequate provision of high-quality, focused training (most likely through post certification EUS fellowships), using the competency and training framework outlined in this document. Additionally, the training of mentors to support newly qualified service providers in their early career of EUS practice should be formalised. This will ultimately result in a high-quality service for patients.

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