Guidelines for the appointment of General Practitioners with Special Interests in undertaking procedures:

Primary Care Society for Gastroenterology
GP Endoscopists Subcommittee

Gastro-intestinal Endoscopy

- **Core activities and competencies required**
  The general practitioner with special interest in gastro-intestinal endoscopy should be competent in performing diagnostic adult endoscopy. This would include one or all of the modalities of endoscopy including gastroscopy, flexible sigmoidoscopy and colonoscopy. These should be performed to levels of safety and accuracy expected of a suitably qualified peer ensuring patient safety, comfort and satisfaction. The GP should work as a team member with the local multi-disciplinary team and collaborate with the Primary Care and Acute Trusts, lead in service development and offer added value by advising and educating local GPs to improve the appropriate use of the service and management of patients with gastroenterological disease.
- **Types of patients suitable for the service.**
  Ambulant patients who have symptoms and/or clinical signs, that indicate the need for an endoscopic examination; in an Acute Trust setting this may include emergency cases requiring interventional procedures; in a primary care setting, patients with conditions severe enough to warrant urgent referral should be referred to a gastroenterologist or surgeon and not to the general practitioner-led service.
- **Facilities**
  Endoscopy should be performed in a unit that complies with BSG guidelines for safe endoscopy. Where endoscopy is performed in a setting outside of a hospital unit, such as in a cottage hospital or GP surgery, facilities, staffing and equipment should be of the same quality. If light conscious sedation is to be used then facilities for resuscitation and recovery should be available to the same standard as in an acute hospital. (As outlined in the SIGN guidelines (http://www.sign.ac.uk) on conscious sedation) Cleaning and disinfection of endoscopes should comply with the practice advised in BSG and COSHH guidelines.
- **Clinical governance, accountability and monitoring arrangements including links with others working in the same clinical area in primary care at PCT level and in acute trusts.**
  The GP will be accountable to the PCT Board. On a day-to-day basis the PCT will agree and implement clear lines of accountability for clinical and contractual issues. However the GP will work as part of a local team. Clinical governance will be co-ordinated with that of the Acute Trust's Gastroenterological and Surgical teams. Regular interaction with colleagues at the Acute Trust is essential. Appraisal and revalidation should be carried out according to national requirements for GPs *but in addition should include input from specialists who are qualified to appraise the area of special interest.*
- **Evidence of Training and acquisition of competence**
  The GP with special interest should demonstrate that training has occurred in line with the JAG* recommendations for training in gastrointestinal endoscopy. Those practitioners who trained before the inception of JAG will have demonstrated

competency through sustained delivery of an equivalent service locally; ideally a local accredited JAG trainer should affirm this.

- **Evidence of continued technical competency**
  The GP with special interest should undertake the minimum number of endoscopies as detailed in the PCSG guidelines.
- **Induction, support and CPD arrangements for the general practitioner with special interests**
  The GP will specify and adhere to an appropriate system of mentoring and continuing professional development. The GP will ensure appropriate cover from a medical defence organisation or the NHS Litigation Authority
- **Local guidelines on use of the service**
  Local guidelines for referral criteria and process measures to be met must be agreed and followed.
- **Monitoring and clinical audit arrangements**
  Clinical audit of the referral criteria above, significant event auditing and arrangements to survey the views of referrers and patients accessing the service must be in place.

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