

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

Gastro-intestinal Endoscopy

- **Core activities and competencies required**

The general practitioner with special interest in gastro-intestinal endoscopy should be competent in performing and reporting 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 recognised levels of safety and accuracy, ensuring patient comfort and satisfaction.

The GP should work as a team member with the local gastrointestinal multi-disciplinary team and collaborate with the Primary Care and Acute Trusts. In the primary care setting the GPwSI should lead in service development and offer added value by advising local GPs in order to improve the appropriate use of the service and management of patients with gastroenterological disease.

- **Types of patients suitable for the service either in an Acute or Community Setting.**

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 this should be limited to diagnostic procedures, appropriate for the relevant unit. Higher risk patients (and higher risk procedures) should be treated (performed) in secondary care via referral to a gastroenterologist or surgeon, and not by the general practitioner-led service (unless competent to perform these procedures, and in an appropriate setting).

- **Facilities**

Endoscopy should be performed in a unit that complies with JAG guidelines for safe endoscopy¹. Some of these standards are still under development. Where endoscopy is performed in a setting outside of a hospital unit, such as in a cottage hospital, diagnostic and treatment centre or GP surgery, facilities,

staffing and equipment should be of the same quality². If conscious sedation is to be used then facilities for resuscitation and recovery should be available to the same standard as in an acute hospital³. Cleaning and decontamination of endoscopes should comply with the practice advised in BSG and COSHH guidelines⁴.

- **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 responsible local Commissioning Group. On a day-to-day basis the Group will agree and implement clear lines of accountability for clinical and contractual issues. However the GP will work as part of a local team, and will have procedures in place to ensure maintenance of competence and further education in the specialty. Where relevant, clinical governance will be co-ordinated with that of local and national teams. In an isolated situation the GP will ensure regular audit, patient satisfaction and personal appraisal. Regular interaction with neighbouring gastroenterology and colorectal teams is desirable. 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 endoscopy¹. 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. In addition the GP should have knowledge of the appropriate Endoscopy Workforce Competencies⁵ (15 in a Primary Care setting, 16 in an Acute setting, appendix A).

- **Evidence of continued technical competence**

The GP with special interest should maintain endoscopic and interpretive skills by a sufficient workload and continuing interaction with other endoscopists and specialists⁶. In addition the GP may be required to monitor the performance of the service and the unit using the Endoscopy Global Rating Scale⁷

- **Induction, support and CPD arrangements for the general practitioner with special interests**

Induction takes place during training. Then the GP will specify and adhere to an appropriate system of mentoring and continuing professional development, It is recommended that each GPwSI sets aside fifteen hours per year for CPD in the area of special interest, and the doctor is expected to keep a personal development portfolio which should form part of the GPwSI annual appraisal. Membership of a professional society such as the PCSG adds value to the personal portfolio⁸. The GP will ensure appropriate cover from a medical defence organisation or the NHS Litigation Authority.

- **Local guidelines on use of the service**

The GPwSI will play a part in the development and review of local guidelines for referral criteria and process measures to be met.

- **Monitoring and clinical audit arrangements**

The GPwSI should play an active role in the community setting (and where appropriate, the acute setting) in the monitoring of the correct use of referral and procedural guidelines. In a community based endoscopy unit, the GPwSI should be involved in the administration of the unit which will include robust administrative backup for the endoscopy service such as audit trails for referrals, histology reports and recall procedures, and also the handling of critical incidents and process failures, and should expect to participate in service review meetings.

References:

1. Joint Advisory Group on Gastrointestinal Endoscopy (2004)
www.thejag.org.uk
2. Endoscopy in Primary Care (2001) www.pcsq.org.uk Endoscopy Section
3. Safety and Sedation During Endoscopic Procedures (2003) www.bsg.org.uk
4. Guidelines on Decontamination of Equipment for Gastrointestinal Endoscopy
www.bsg.org.uk (Guidelines section)
5. Endoscopy Workforce Competence (2005) Skills for Health
<http://www.skillsforhealth.org.uk>
6. Endoscopy in Primary Care 1995 www.bsg.org.uk
7. Endoscopy Global Rating Scale (2005) www.grs.nhs.uk
8. General Practitioners with Special Interests (January 2006) Royal College of General Practitioners http://www.rcgp.org.uk/pdf/ISS_INFO_11_JAN06.pdf

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APPENDIX A

- END1** **Communicate and relate to individuals during endoscopic procedures**
- END2** **Provide information on endoscopic procedures to individuals**
- END3** **Refer individuals for endoscopic procedures**
- END5** **Agree endoscopic procedures for individuals**
- END7** **Prepare individuals for endoscopic procedures**
- END9** **Assist colleagues during endoscopic procedures**
- END10** **Administer sedation and analgesia to individuals during endoscopic procedures**
- END11** **Assess and optimise the condition of individuals during endoscopic procedures**
- END12** **Perform diagnostic and therapeutic endoscopic procedures**
- END13** **Identify signs of abnormality revealed by endoscopic procedures**
- END14** **Collect specimens through the use of endoscopic procedures**
- END15** **Manage polyps through the use of endoscopic procedures**
- *END16** *Manage strictures through the use of endoscopic procedures*
- END17** **Manage haemostasis through the use of endoscopic procedures**
- END18** **Review the results of endoscopic procedures**
- END19** **Provide reports on endoscopic procedures**

***Acute hospital setting only**