JAG
Joint Advisory Group
on GI Endoscopy

# Policy statement for pooling

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Pooling of gastrointestinal endoscopy referrals has helped contribute to the massive reduction in waiting times. However, as low waits are sustained the need for pooling diminishes. There are advantages and disadvantages to pooling in the context of low waits.

**Advantages**

- Pooling a proportion of referrals (perhaps 30%) maximises the efficiency of booking. It is difficult to match demand from outpatients from a single endoscopist with his capacity in endoscopy. Inevitably there will be unfilled slots. This will reduce efficiency and put waits at risk. Pooling allows spare slots to be filled.
- Pooling creates an internal vetting process. Pooling raises awareness of differences in referral thresholds and acts as an additional check on appropriateness.
- Pooling improves the quality of the procedure: a referrer must be satisfied that his colleague will be competent to do the procedure. Pooling acts a driver to improve the levels of competence.
- Pooling exposes endoscopists to the clinical judgements and behaviours of their colleagues. This spreads good and innovative practice (such as direct referral to a coeliac clinic following duodenal biopsy for positive TTG) and raises awareness of poor practice (such as inadequate explanation of, or consent for the procedure).

**Disadvantages**

The main disadvantage of pooling is that it disrupts continuity of care. This has several potential adverse effects on the patient:

- There may be unnecessary subsequent appointments.
- It can lengthen the time to treatment.
- The endoscopist may not be aware of the nuances of the patient's problem and this may adversely affect interpretation of findings or decisions about subsequent care.
- Patients have to get used to another clinician. As a general rule patients prefer to have continuity of care and see the same clinician throughout the episode (providing it is appropriate to do so).

It can be seen that the advantages favour the system and learning for endoscopists, whereas the disadvantages affect patient care. It is recommended that individual sites create their own policy on pooling based on these disadvantages and advantages.

It is recommended that patients who wish for their procedure to be done as quickly as possible, and who have relatively straightforward clinical problems, are pooled. This will represent up to 30% of patients seen in clinic. This proportion should be sufficient to allow efficient use of capacity, achieve some of the benefits in learning and sharing of practice outlined above and not compromise individual patient care.



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