weekly feedback and support via WhatsApp. Trainees were required to perform procedures with all 3 present: one carrying out the OGD, the 2nd supporting with vocal prompts and the 3rd recording the procedure via mobile technology. DOPS feedback took place on each case locally and supplementary feedback was delivered by UK faculty following video review. In 2017 the UK team revisited Freetown and provided further training on live cases. Each trainee underwent an oral viva examination and were assessed by 2 trainers over an OGD case by summative DOPS. In 2018 at the time of a third visit, the 3 trainees were again assessed with a focus on report writing and pathology recognition.

Results To date 290 OGDs have been performed by Freetown doctors without complication. At the time of the second visit in 2017, all trainees satisfied DOPS criteria demonstrating competent, safe practice and were awarded “provisional certification” and continued to practice in pairs. In 2018, all trainees demonstrated additional periprocedural competence and knowledge and were granted “full certification” to practice alone, with the proviso that they continued to provide videos of pathology as part of ongoing remote support. 250 procedures had been performed by the team at this point in time with high quality KPIs of D2 intubation and retroflexion occurring in >90% of cases. Train the Trainer training was delivered to Freetown endoscopists in 2018 and utilised in training 3 new trainees.

Conclusion A sustainable OGD service can be developed using intermittent direct supervision and remote mentoring. The use of intense procedural visualisation, trainee to trainee feedback and highly supportive trainers are identified as critical elements to achieve this. Similar models could be applied in other developing countries.