individuals including co-morbidity and time of bleeding, variation in local practises may have a bearing on outcomes. This study evaluates whether facilities provided at differing centres can influence outcomes of AUGIB, with findings compared to the BSG National Audit (Hearnshaw *et al* 2011).

Methods Data was prospectively collected from five South Yorkshire hospitals (Northern General Hospital, Royal Hallamshire Hospital, Rotherham District General Hospital, Chesterfield Royal Hospital and Barnsley District General Hospital) between Sept-Dec 2011. This included demographic, clinical and endoscopic findings in all AUGIB patients, alongside 30-day mortality outcomes. Patients were risk stratified using pre-endoscopy Rockall scores with comparisons made with national audit results using standardised mortality ratios (SMR). In addition, service provision for AUGIB within each unit was collected. $\chi 2$ analysis was used to compare categorical data, with p values < 0.05 considered significant.

Results A total of 796 patients (438 male, median age 65 years, range 16–86) were admitted at all sites with AUGIB during the 3-month study period. Of these patients, 33.7% (268/796) had a pre-endoscopy Rockall score of 6 or above, significantly higher than the 5.9% identified in the national audit (p = < 0.001). All hospitals in South Yorkshire had out of hours (OOH) endoscopy rotas (national audit = 52%), a nurse on call rota (national audit = 37%) and facilities to undertake OOH endoscopy (national audit = 92%). Whilst no statistical difference was identified in mortality between individual hospitals in South Yorkshire (p = 0.406), both risk-standardised mortality ratios and inpatient mortality in South Yorkshire were significantly lower than national audit findings (Table 1).

Abstract PTU-041 Table 1 Comparisons between South Yorkshire and National Audit populations

	South Yorkshire Data (n = 796)	National Audit (n = 6750)	p-value
Median Pre-Endoscopy Rockall Score	5	3	N/A
New Admissions Mortality	7.3%	7%	0.69
Inpatient Mortality	15.9%	26%	0.02*
Overall mortality	8.5%	10%	0.21

*Significant result

Conclusion Despite a higher pre-endoscopy Rockall Score in our cohort, both our risk adjusted mortality and inpatient mortality rates were significantly lower than the national audit findings. We believe that these outcomes are reflective of having dedicated GI bleed services, with provision and staffing of OOH endoscopy rotas, enabling us to provide quicker and more comprehensive services to our patients.

Disclosure of Interest None Declared

PTU-042 ENDOSCOCOPIC TRAINING IN UPPER GASTROINTESTINAL BLEEDING (UGIB): A BSG REGIONAL AND NATIONAL AUDIT

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[1,*]E F Wong, [1]M Kurien, [1]E Ejenavi, [1]M Lau, [2]C Romaya, [1]F Gohar, [3]K L Dear, [4]K Kapur, [5]B Hoeroldt, [1]A J Lobo, [1]D S Sanders. *[1]Department of Gastroenterology, Royal Hallamshire Hospital, Sheffield; [2]BSG, London; [3]Department of Gastroenterology, Chesterfield Hospital, Chesterfield; [4]Department of Gastroenterology, Barnsley Hospital, Barnsley; [5]Department of Gastroenterology, Rotherham Hospital, Rotherham, UK*

Introduction UGIB is a common emergency frequently requiring endoscopic intervention. Training in therapeutic endoscopy for UGIB is not mandatory. Furthermore UGIB endoscopic experience may be diminished by the European Working Time Directive and a Consultant delivered service. There has been no published data on trainees' opportunities for UGIB endoscopic experience. This study evaluates GI trainee experience in the South Yorkshire (SY) region and nationally.

Methods Rockall scores for patients requiring an endoscopy for an UGIB (n = 622, 5 hospitals) was prospectively collected in SY between Sept-Dec 2011. Trainee experience from this cohort was then compared with a historical SY UGIB cohort (n = 274) from 1996. Nationally, all BSG trainees (n = 478) were invited to respond to a custom designed web based questionnaire (Nov-Dec. 2012). Information was collected about OGD competency (both diagnostic and therapeutic) and trainees' confidence of acquiring sufficient endoscopic skills in UGIB prior to completing specialty training.

Results Regionally, comparison between the 2011 and 1996 SY UGIB cohorts demonstrated comparable 30-day mortality rates (8.5% vs 8.1%, p = 0.78), with similar median post-endoscopy Rockall scores (6 v 5). When comparisons were made between trainee and non-trainee performed procedures, no mortality difference was identified (p = 0.286). However, when comparing trainee undertaken procedures between the two cohorts, a significant decline was observed with 76% (208/274) of endoscopic procedures for UGIB being performed by trainees in 1996 compared with only 16% (97/622) in 2011 (p < 0.0001). Nationally, questionnaires were returned by 51% (245/478) of BSG trainees (median = 4 years registrar training, range 1–9 years). Of these, 42% (104/245) had completed a basic upper GI endoscopy training course and 40% a therapeutic course. Median number of OGD's performed by trainees was 500, with therapeutic exposure < 10% in 76% of cases. 23% (57/245) of trainees felt their endoscopic skills in UGIB will be insufficient at the time of specialty training completion.

Conclusion This study objectively demonstrates a decline in regional training for gastroenterology trainees in UGIB endoscopic procedures. Furthermore our regional audit is supported by the National audit, which suggests that trainees across the UK are both limited in their opportunities and concerned that a level of competency may not be attained during registrar training. We advocate reviewing UK endoscopic training provision for UGIB ensuring qualified and confident endoscopists are produced to meet future service needs.

Disclosure of Interest None Declared

PTU-043 DIAGNOSTIC YIELD AND SAFETY OF SMALL BOWEL CAPSULE ENDOSCOPY

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[1,*]E Houston, [1]R Rivera-Forrester, [1]N Haslam, [1]A Morris, [1]P Reid, [1]P Collins. *[1]Gastroenterology, Royal Liverpool University Hospital, Liverpool, UK*

Introduction Small bowel capsule endoscopy (CE) is a minimally-invasive, established tool for the detection of small bowel lesions.

Methods All capsule endoscopy reports from Jan 2007 to Aug 2012 performed at the Royal Liverpool University Hospital were reviewed.

Results A total of 311 examinations were performed during the period of review. Patients undergoing CE had a median age of 53 years (range 15 – 88) and a male:female ratio of 48.6%:57%.

The commonest indication for examination was unexplained iron deficiency anaemia (IDA) (48.6%). Other indications included assessment for suspected Crohn's disease (23.5%), obscure overt GI blood loss (11.9%), polyposis syndrome (3.9%), diarrhoea (2.6%)and investigation of refractory coeliac disease (1.6%).

The median gastric transit time was 19 mins (range 0 – 276 mins). The median small bowel transit time was 245 mins (range 61–533 mins). The capsule failed to reach the colon in 17.4% of cases.