

Introduction A range of techniques have been described to achieve successful cannulation at ERCP, and when training in ERCP it is often difficult to select the optimum approach¹. There are potential advantages to a wire-led approach and we have evaluated this in our unit in a training setting.

Aim To evaluate cannulation success rates for trainers and trainees using a wire-led technique as the default approach.

Methods A prospective evaluation was done with 2 experienced trainers and 2 trainees (previous experience of 50–100 ERCPs each). The sphincterotome was pre-loaded with a hydrophilic wire (in limited cases loop tip wire was used) and cannulation started with the wire extending 3–5 mm out of cannula. Attempts were then made to advance the wire deep into the bile duct before injecting any contrast or pushing the cannula through the ampulla. Trainees were allowed 6 min for cannulation attempts. If the wire-led approach failed then other techniques were used. Wire-led cannulation was considered successful only if no other techniques were required. Only cases with a 'virgin ampulla' were included in this study.

Results 85 cases were included over a 4 month period. Trainees were present in 51/85 (60%) cases. Overall biliary cannulation success was 78/85 (92%). Success rate was 45/51 (88%) if a trainee was present and 33/34 (97%), if no trainee was present. Independent success for trainees was 25/51 (49%), mostly using the wire-led technique (21/25) 84%. In cases where a trainer took over from a trainee, the wire-led approach was still successful in 13/26 (50%).

Overall success with the wire-led approach alone was 57/85 (67%); other approaches used in remaining cases included precut sphincterotomy, locked PD wire, and PD stent. A periampullary diverticulum was the most common cause for failure of wire-led technique; other common causes included stricture, floppy ampulla, or an impacted stone.

Median cannulation time was 6.5 min (IQR 4–10 min) overall and 5 min (IQR 3–10 min) for consultant-only cases. Immediate complications included false passage of wire (1 case, no further clinical events) and late complications: post ERCP pancreatitis (1 case, hospital stay 3 days, no further clinical events).

Conclusion Wire-led biliary cannulation, with selective usage of additional techniques, may allow a cannulation rate of >90% in cases with a virgin ampulla. The technique appears to be a useful training tool and has a low complication rate.

REFERENCE

1 Gastrointest Endoscopy *Clin N Am* 2012 Jul;22(3):417–34

Disclosure of Interest None Declared.

PTU-003 GASTROSCOPY CONSENT TRAINING FOR FOUNDATION DOCTORS: A NOVEL TEACHING STRATEGY

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Introduction Postgraduate Medical Education and Training Board (PMETB), now part of General Medical Council, reports on Foundation Schools have highlighted lack of consent training among Foundation Year 1 doctors (FY1s).¹ This can impact on patient safety and misguide expectations, thus adversely affecting patient experience. It could also affect FY1s' confidence as they often feel they obtain consent for procedures without adequate training. Robust consenting skills are integral to good medical practice and require urgent attention. Hence we developed a new

teaching programme on consenting for diagnostic gastroscopy (DG), which is the commonest inpatient procedure undertaken in the endoscopy unit, and as this procedure is less complex with relatively rare serious complications.

Methods We initiated an *apprenticeship model* of training for consenting as part of mandatory FY1 induction. To facilitate this, we designed a formal assessment tool called Direct Observation of Gastroscopy Consent Taking Skills (DOGCTS). We developed a three-stage process. Stage 1: FY1s were provided small group teaching on consent and procedure. Stage 2: FY1s chose from available list of training slots, which were published after liaison between Endoscopy Unit and East Riding Medical Education Centre. Stage 3: FY1s observed one consenting process and DG by experienced endoscopist and underwent formal assessment using DOGCTS tool.

Results This pioneering programme was introduced to all FY1s working in Medicine and Surgery in HRI starting in August 2012. Since its inception, 139 FYs have been trained with 100% attendance rate. In order to avoid disruption to lists, only one FY1 was trained per list. Programme allowed FY1s to plan training around their clinical commitments. Successful completion of DOGCTS has been integrated into FY portfolio-requirements. Feedback from FYs has been positive and they have reported improved confidence. Patients have informally expressed that they had a better patient experience.

Conclusion Development of such a novel *apprenticeship model* allows for trainees and trainers to interact in an open, inclusive and non-threatening manner. It provides FY1s flexibility to manage their learning needs and trainers a chance to give formative feedback in real-time. Such a dynamic approach can not only improve confidence of FY1s but also instil public confidence in healthcare training. It has provided an excellent training opportunity in addition to being useful evidence for training-portfolios. It also caters to quality assurance and medico-legal aspects (pertaining to consenting) for NHS Trusts. We aim to undertake a formal survey of patient satisfaction annually and roll out this programme for flexible sigmoidoscopy consent as well.

REFERENCE

1 PMETB Report on Quality Assurance of FY1 programme visit to London deanery 2009

Disclosure of Interest None Declared.

PTU-004 APPLYING CLINICAL FRAMEWORKS AND MODELS TO IMPROVE THE SPECIALIST SCREENING PRACTITIONERS (SSP) SKILLS WHEN BREAKING BAD NEWS WITHIN THE BOWEL SCREENING WALES (BSW) PROGRAMME

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Introduction Communicating a life altering diagnosis to a participant is considered to be one of the most difficult aspects of the SSP role. Research would suggest that screen detected cancers are likely to be asymptomatic and in the absence of warning signs there is little time for people to prepare for such news. Screening diagnosis often show positive appraisals with an understanding that the disease may be curable through early diagnosis. The aim of this work is to determine the skills involved when the SSP breaks bad news to the participants within the bowel screening programme in Wales. Using personal reflection, clinical frameworks and models are assessed to