establish if they can be used effectively to utilise these skills in the delivery of bad news.

Methods A literature review of the current research into reflection and breaking bad news was undertaken; from this a number of consultation frameworks were selected, namely:

Models of Communication
SPIKES (Breaking bad news)
The MacMaster Technique
Reflective Practice and the use of Gibbs reflective cycle

Key themes were identified in terms of professional and personal responsibility, particularly around communication, during the process of breaking bad news. These were adopted into clinical practice. Using Gibbs reflective cycle, personal reflection was undertaken during this transition phase and results noted.

Results Effective communication in breaking bad news demonstrating empathy and respect is vitally important, and one could argue as significant as treating the person who has a cancer diagnosis. The manner in which the information is imparted to the participant and their family can have serious consequences on their psychological morbidity and their ability to engage with the decision making processes in regard to their healthcare management.

Application of the structure from the Calgary Cambridge Consultation Framework, supported by the SPIKES communication model and the MacMaster Technique, provides the necessary tools to support the participant through potentially difficult clinical consultations. Likewise, practitioners are able to manage the consultation and have a clear process to follow, allowing for respect, empathy and support for the participants; thus augmenting the quality of service provided.

Conclusion It is essential that SSPs have the knowledge and skills to furnish them for effective communication skills to break bad news and to support participants and their families. Implementation of these frameworks has been found to provide the tool with which the SSP can be supported in their clinical practice and also sustain their participants when communicating a life altering diagnosis.

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Disclosure of Interest None Declared.

PTU-005 FACTORS INFLUENCING THE QUALITY OF COLONOSCOPY TRAINING IN THE NORTH WEST DEANERY

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Introduction Endoscopy is integral to the JRCPTB Gastroenterology Curriculum and the JAG clearly defines competencies that must be achieved before independent practice. Training in colonoscopy for Gastroenterology Specialty Trainees (ST) can be challenging due to current work patterns and non-GI commitments. We aimed to evaluate the opportunities for and the quality of colonoscopy training in the NW Deanery as perceived by STs.

Methods An electronic questionnaire was sent to all Gastroenterology STs enrolled within the NW Deanery including questions based on data which would be available from the JETS e-portfolio. STs were excluded at the point of entering OOP activity. To allow comparison, number of procedures performed was standardised to year of training and to length of time in each post. We used an arbitrary minimum expected number of procedures per year at each level of training to calculate adequacy of training opportunities.

Results 29 trainees completed the survey (ST3=3, ST4=8, ST5=4, ST6=6, ST7=1, OOP = 7) at 13 sites. 7 (24%) had achieved JAG accreditation for diagnostic colonoscopy. Overall completion rate (CR) was 52.2% (0 to 97%). Mean number of colonoscopies (and independent CR) was: ST3=25.6 (7%), ST4=68.9 (19%), ST5=103.3 (65%), ST6=105.7 (87%), ST7=66 (92%). 5 (17%) STs had a CR of >90% and had performed an average of 270 procedures to attain this level. The average number of colonoscopies per year for each individual site ranged from 34% to 160% of expected procedures. 22 (76%) STs had used a scope guide and 33% of these STs found it useful. 62% of trainees were satisfied with the level of supervision during endoscopy. 62% of trainers had completed a TCT course or equivalent but 14% of STs did not know. The major limiting factor affecting colonoscopy training was GIM commitments (72%) with lists missed due to on call shifts. 41% reported that training lists were not tailored to their needs, 38% missed lists due to lack of ward cover and 38% did not feel that they had enough colonoscopy lists. Other factors affecting colonoscopy training included competition with nurse endoscopists (10%) and trainers taking over too early (14%). 24% of STs rated their satisfaction with colonoscopy training at 4 or 5 (on a scale of 1 to 5, where 1 was poor and 5 was excellent).

Conclusion There is considerable variability in opportunities and quality of colonoscopy training in the NW Deanery. Service provision must be balanced with a structured, high quality training programme to ensure that colonoscopy performance can meet the mandatory standards expected at the time of CCT. In our region, it is reassuring that STs seem to achieve these targets by ST7 despite the challenges we identified. This study provides a baseline for future quality improvement in NW Deanery colonoscopy training.

Disclosure of Interest None Declared.

PTU-006 GASTROENTEROLOGY TRAINEES EXPRESS AN INTEREST TO LEARN TO PERFORM ULTRASOUND-ASSISTED LIVER BIOPSIES: RESULTS OF A NATIONAL SURVEY (UK)

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Introduction Liver biopsy for the assessment of parenchymal liver disease is increasingly performed under direct ultrasound guidance by radiologists. As such, it is no longer a mandatory requirement for hepatology trainees in the UK to achieve competence in this procedure.

Methods We aimed to determine whether trainees are receiving training to perform ultrasound-assisted liver biopsies; and whether they would be interested in doing so if not. Trainees anonymously responded to a 10 question, web based survey using a combination of pre-defined answers in drop down boxes and free text answers.

Results Surveys were sent to approximately 800 trainees. 226 surveys were returned. Respondents represented all training

grades (ST3-ST7). 75 respondents (33%) intend to pursue subspecialty accreditation in hepatology. 103 respondents (46%) have completed a period of training in a tertiary/transplant centre.

105 respondents (47%) have worked in a centre where physicians perform liver biopsies. 52 (23%) have been offered the opportunity to learn how to perform ultrasound assisted liver biopsy and 38 (17%) have been assessed and deemed competent in the procedure. Three respondents commented that they are trained in unguided liver biopsy; one trainee has used the Sonosite probe and one commented that he/she has performed liver biopsy after an appropriate site was marked by the radiologist

137 (61%) of trainees who responded to the survey would be interested in learning how to perform this procedure and a further 29 (13%) may be interested. 138 (61%) of respondents would be interested in attending a hands-on course to learn this procedure and 30 (13%) may be interested. Of the 75 respondents who intend to pursue subspecialty hepatology accreditation, 72 said they would be interested in learning how to perform ultrasound assisted liver biopsy.

Trainees who participated in this survey reported that opportunities to learn this procedure were currently hit and miss. There were concerns about the practicality of maintaining competence during training and as a consultant and some respondents felt that it was safer for the procedure to be performed by radiologists.

We cannot report the views of trainees who did not complete the survey and therefore our results may not be representative. However even if we make the assumption that all non-responders are not interested in learning this procedure, there is still an estimated 15–20% of trainees that would be interested (137/~800).

Conclusion Trainees participating in this survey are interested in learning to perform ultrasound-assisted liver biopsies, but the infrastructure to offer this training is not currently well established. Discussion between trainees and training bodies should be considered to explore this issue further.

Disclosure of Interest None Declared.

PTU-007 DEVELOPMENT OF A SMARTPHONE APP TO AID THE CLINICAL MANAGEMENT OF POLYPOSIS SYNDROMES

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Introduction Smartphone "apps" are becoming increasingly used by health care professionals (HCPs) as a quick and easy guide for delivering evidence-based medicine. "Apps" are particularly effective in providing guidelines accessible from a smartphone with contents that can be updated frequently. The Polyposis Registry at our institution has spearheaded the formulation of guidelines for the management of inherited polyposis syndromes. We set out to develop these into "app" form.

Methods Essential content of our institution's guidelines (based on published guidelines) was selected by a multidisciplinary team and edited to suitable format for the "app" programmers, and a trial version was produced. This was tested by a group of HCPs (colorectal surgeons, gastroenterologists, nurse specialists). A questionnaire was sent out after the trial to determine the usefulness and effectiveness of the "app".

Results Eighteen HCPs trialled the "app". 89% found it relevant and useful in their clinical practice, and would use it at least once a month. 83% said that it provided the information they required, and all would recommend it to a colleague. None considered it hard to use. Some improvements were suggested, which will be implemented in the final version offered externally.

Conclusion We present an "app" which provides our evidence-based guidelines for the management of polyposis syndromes in an easily accessible and updatable form, and describe its development.

Disclosure of Interest None Declared.

PTU-008 DEDICATED COLONOSCOPY TRAINING LISTS IMPROVE TRAINEE COMPLETION RATES TO MATCH A CONSULTANT BENCHMARK

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Introduction Colonoscopy is the gold standard modality for investigation of colonic disease.[1] The procedure can be challenging to perform.[1] Complete colonoscopy, defined as intubation of the terminal ileum, neo-terminal ileum, or caecum, should be achieved in greater than 90% of cases on an intention to complete basis.[1] Historically trainees have performed colonoscopy on service lists, and ad hoc training lists and may have had incomplete access to training.[2] Trainees currently working in our unit perform colonoscopy on dedicated training lists prior to JAG certification of independence. We performed a large retrospective study of colonoscopy completion rate, comparing two groups of gastroenterology trainees with consultant Gastroenterologists.

Methods 5307 consecutive colonoscopies, from a five-year period in a single centre, were triaged by first endoscopist. Groups identified were 1) consultant Gastroenterologists 2) previous trainees (individuals who trained in the unit in the past, performing colonoscopy on service, adhoc training, and dedicated training lists) 3) Current trainees (employed in the unit at time of study, performing colonoscopy on dedicated training lists). Colonoscopy completion rate, as defined above, was determined for each group. Odds ratios and 95% confidence intervals were calculated to compare the completion rate between groups.

Results Results are summarised in the table

Conclusion Consultants were more likely to achieve complete colonoscopy than previous trainees, who did not achieve >90%

Abstract PTU-008 Table 1

Group	Total colonoscopies	Complete procedures	Probability of completion	OR	95% CI
Consultant	4439	4104	0.92	X	X
Previous trainees	646	561	0.87	1.72	1.44–2.39
Current trainees	222	206	0.93	0.95	0.57–1.60