chest X-ray film). Furthermore, the authors sought to identify whether these medical schools included formative or summative assessment of the respective methods.

Methods All 30 GMC recognised Medical Schools within the UK were invited to participate by means of a standardised survey proforma. This proforma was emailed to relevant staff members who were either responsible for course development or were personnel within the clinical skills faculty.

Results To date, there has been a 57% (17/30) response rate (Table 1).

Abstract PTU-011 Table 1

	Number of Medical Schools
Formal teaching on NG tube insertion provided	10
Methods employed in assessing appropriate tube position:	
pH Testing	10
CXR interpretation	6

Of the 10 medical schools that provide formal teaching on NGT insertion, 8 of them required formative assessment for both the practical technique and the interpretation of correct tube position.

Of the 7 medical schools that do not to provide formal teaching of NGT insertion, 6 of them stated that this was due to the GMC's "Tomorrow's Doctors" guidance not including NGT placement as a mandatory proficiency for a graduate.

Conclusion This survey found that 59% (10/17) of the participating UK medical schools provide formal teaching on NGT placement and correct identification of tube position. There is variable emphasis on NGT procedure proficiency in undergraduate medical education. Given the risks highlighted by the 2011 NPSA report, we would suggest that NGT placement instruction and training should be facilitated at the undergraduate level.

Disclosure of Interest None Declared

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PTU-012 ENDOSCOPY TRAINING USING SIMULATORS: WHAT FACTORS AFFECT TRAINEE MOTIVATION TO LEARN?

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Introduction Simulation is increasingly being advocated to enhance training in complex technical skills such as endoscopy. While a growing body of evidence suggests simulation use within a study context can improve technical and non-technical skills [1], little attention has been paid to the learning experiences of trainee doctors using simulators to learn such skills.

Motivation is an important component of effective learning but anecdotal evidence suggests some trainees may be less motivated to learn in a simulated environment than in traditional training.

Aim To determine which factors trainee doctors identified as positively and negatively affecting levels of motivation during endoscopy training using a simulator.

Methods We invited a cohort of surgical and medical gastroenterology trainees to participate in semi-structured interviews. 6 trainees who had used an endoscopy simulator as part of their regular training were purposively selected to include a range of stages of training. We analysed the recorded interviews in an inductive

fashion from an interpretivist perspective concentrating on key themes, outlying cases and use of language to develop insight into factors affecting motivation.

Results Major emergent themes specific to simulator use included:

- Context of simulator use including: Physical environment, professional and educational
- Positive impact of intermittent rather than continuous supervisor presence and feedback
- Recognising limitations of utility

Differences in individual preferences relating to the above issues was also emphasised suggesting, where possible, a tailored approach would maximise motivation. The limitations of simulator based learning was repeatedly mentioned by senior trainees, with a suggestion that being forced to learn on simulators beyond a point where they were perceived useful could have a detrimental impact on motivation. However, several trainees identified alternative uses such as team training exercises which could provide motivating simulator based learning at more senior levels.

Conclusion The above issues should be considered in all units using simulators in training for endoscopy or similar complex technical skills. The impact of the physical environment, altered role of the supervisor and optimum methods of delivering feedback in simulator based endoscopy training merit further exploration.

As simulator based learning becomes more widely available, careful consideration of how it is used at different stages of the endoscopy curriculum is required.

Disclosure of Interest None Declared

REFERENCE

1. Cochrane Database Syst Rev. 2012 Jun 13; 6:CD008237

PTU-013 THE IMPACT OF EDUCATION ON FLUID PRESCRIBING AMONGST JUNIOR DOCTORS

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Introduction Gastroenterology patients frequently require intravenous fluids but inappropriate prescription is associated with poorer outcomes (1). Educational initiatives can improve fluid prescription (2) and this study examines knowledge of electrolyte requirements and post-operative fluid prescription amongst final year medical students and junior doctors, ten years on from the paper by Lobo *et al* (3).

Methods 56 junior doctors and final year medical students in a large UK teaching hospital answered a questionnaire on fluid prescribing practice before attending a formal teaching session on the topic where they also received a pocket handbook on Trust prescribing guidelines. Six months later they were asked to repeat the questionnaire. There were 36 respondents after the teaching session.

Results Prior to the teaching 25% did not feel confident with fluid prescribing and 34% felt they had unsatisfactory or poor teaching at medical school. 18% stated that fluid balance charts were not checked regularly. Only 10% of respondents were aware of the sodium content of normal saline and 9% would prescribe two or more litres of normal saline per day in a post-operative patient.

After the teaching session 94% felt confident with fluid prescribing and 64% knew the sodium content of normal saline. 5% would prescribe two or more litres of normal saline per day in a post-operative patient.

Conclusion Knowledge of electrolyte requirements and fluid prescribing is still inadequate, but a teaching session with a handout significantly improved knowledge and confidence in prescribing. The six months of experience gained in this time may be a confounding factor, but as the questionnaires indicated lack of fluid

Abstract PTU-013 Table 1

	Lobo et al, 2001	Current study		
		Pre teaching (n = 56)	Post teaching (n = 36)	p value
Not confident in prescribing	14%	25%	6%	p = 0.02
Unsatisfactory or poor teaching in Medical school	34%	34%	-	-
Not given guidelines at induction	67%	48%	-	-
Fluid balance charts not checked regularly	3%	18%	22%	p = 0.6
Correct sodium content of normal saline	34%	10%	64%	p < 0.0001
> 2 litres normal saline prescribed	32%	9%	5%	p = 0.7

chart review with seniors or other relevant teaching sessions, their main source of knowledge was postulated to be from our teaching. More attention should be given to this subject in medical schools and guidance should be given at Trust inductions.

Disclosure of Interest None Declared

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PTU-014 IMPACT OF PRIMARY CARE EDUCATION ON THE TWO WEEK WAIT REFERRAL PROCESS FOR GI CANCERS

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Introduction The two week wait referral process was introduced in 2000 to improve cancer prognosis in the UK with an anticipated 20% reduction in cancer-related deaths. The cancer yield has in fact been reported as 9–16%. Referrals should be made on the basis of NICE guidance. Previous studies have highlighted that as few as 53% of referrals from Primary Care have been within NICE guidance. The Government's nine-week "Be clear on cancer" campaign launched in January 2012 via online, TV and radio adverts to increase public awareness of bowel cancer symptoms impacted our service. The proportion of colonoscopies done for the two-week wait service increased from 27% to 48% in the month after the campaign. It is clearly important that referrals made are appropriate to justify this service requirement. This study compares referrals and outcomes before and after a GP education session.

Methods Two week wait GI Referrals to the Horton General Hospital between December 2011 and February 2012 were assessed. A presentation was given to Primary Care Practitioners in May highlighting NICE guidance and referrals were re-audited in June 2012.

Results 100% of referrals met the two week wait target (to clinic, CT scan or endoscopy) and the mean time to first test was 9 days. The results are summarised below. 24% of Upper GI referrals did not meet NICE guidance, mostly patients referred with anaemia above the referral threshold or for dyspepsia without concerning features. The cancer pick-up was 8.6% (2 oesophageal, 2 gastric and 4 pancreatico-biliary). 26% of Lower GI referrals were non-compliant with guidance (mostly due to rectal bleeding or change in bowel habit shorter than the required time). Cancer pick-up was 5.1%. All but one GI cancer was detected in appropriately referred patients.

In June 2012 compliance improved to 81% of upper GI and 79% of lower GI referrals. Reasons for referral outside NICE guidance

were similar to the previous cohort. Cancer detection rose to 12.9% for Upper GI and 8.6% for Lower GI cancers. All cancers in the second audit were in appropriately referred patients.

Abstract PTU-014 Table

	Dec 2011-Feb 2012		June 2012	
	Upper GI	Lower GI	Upper GI	Lower GI
Mean age	71 years	61 years	70 years	68 years
Gender	46% male	43% male	38% male	43% male
% compliance with NICE guidance	76%	74%	81%	79%
Cancer pick up	8.6%	5.1%	12.9%	8.6%

Conclusion The study highlights the importance of communication with Primary Care Practitioners who are responsible for referrals for GI cancer exclusion. There have been previous education sessions but despite this there remains an advantage in re-stating the message and keeping regular contact. The cancer detection rate improved with better compliance with NICE guidance and may indicate the value of adhering to this guidance. Larger studies are required to validate this.

Disclosure of Interest None Declared

PTU-015 TRAINEE ENDOSCOPIC PROCEDURES BY DEANERY AND YEAR OF TRAINING IN THE UNITED KINGDOM: AUGUST 2011 TO JULY 2012. ARE WE DOING ENOUGH?

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Introduction The burden of acute medicine on specialty trainee registrars (StR) is rising. Anecdotal evidence suggests that fewer endoscopic procedures are being performed by gastroenterology (GI) StR's and that trainees although competent at the time of being awarded their CCT may have less confidence in their endoscopic skills when compared to a historical cohort. The annual review of competency progression (ARCP) decision aid includes indicative numbers of procedures which should be undertaken annually. Since September 2010 all endoscopic procedures undertaken by UK GI trainees have been recorded on a national electronic record (the Joint Advisory Group Endoscopy Training System (JETS)).

Methods We obtained anonymised records from the JETS database for the period 3 August 2011 – 31 July 2012. We analysed the data by trainee grade (ST3–7, locum appointment for training (LAT's)), deanery, numbers and type of procedure, and annual numbers of endoscopy lists (dedicated training, ad-hoc training, and service). Duplicate entries & blank entries were removed.

Results A total of 721 records were obtained from the 19 UK deaneries. 183 blank records were deleted leaving 538 for analysis. 49 (9.1%) were ST3 trainees, 101 (18.8%) ST4, 142 (26.4%) ST5, 120 (22.3%) ST6, 102 (18.9%) ST7, and 24 (4.5%) LAT. Significant