

**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 approach<sup>1</sup>. 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).<sup>1</sup> 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

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.

#### REFERENCES

Buckman R, Kason Y (1992)  
Gibbs G (1988)  
Kaplan M (2010)  
Kurtz S, Silverman J (1996)

**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