PTU-81 JAG CONSENSUS STATEMENTS FOR TRAINING AND CERTIFICATION IN ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP)

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Introduction Despite the high-risk nature of endoscopic retrograde cholangiopancreatography (ERCP), a robust and standardised credentialing process to ensure competency before independent practice is lacking worldwide. On behalf of the Joint Advisory Group (JAG), we aimed to develop evidence-based recommendations to form the framework of ERCP training and certification in the UK.

Methods Under the oversight of JAG, a modified Delphi process was conducted with stakeholder representation from the British Society of Gastroenterology, Association of Upper Gastrointestinal Surgeons, trainees and trainers. Recommendations on ERCP training and certification were formulated after formal literature review and appraised using the GRADE tool. These were subjected to electronic voting to achieve consensus. Accepted statements were peer-reviewed by JAG and relevant Specialist Advisory Committees before incorporation into the ERCP certification pathway.

Results In total, 27 recommendation statements were generated for the following domains: definition of competence (9 statements), acquisition of competence (8 statements), assessment of competence (6 statements) and post-certification support (4 statements). The consensus process led to following criteria

Abstract PTU-18 Table 1 Summary of recommendations for training and certification in endoscopic retrograde cholangiopancreatography (ERCP)

Recommendation Statement	Level of Evidence	Strength of Recommendation
1.1 ERCP competence should be defined as the ability to independently carry out effective procedures across a spectrum of case difficulty and case contexts with acceptable safety	Low	Strong
1.2 ERCP is an advanced therapeutic procedure which is operator-dependent and requires specific knowledge and skills-based training to achieve competence	Low	Strong
1.3 The rate of successful selective deep cannulation of duct of interest is an important determinant of competency and correlates with improved performance, but it should not serve as the sole marker of competency	High	Strong
1.4 ERCP training should take place within a structured training programme to achieve the requisite knowledge and skill-based competencies	Low	Strong
1.5 Trainees are required to demonstrate non-technical skills of ERCP (i.e. communication skills, situational awareness, leadership and judgement)	Low	Strong
1.6 The modified Schutz score should be used to grade the difficulty of ERCP procedures	Low	Strong
1.7 Successful completion of an ERCP is defined as the completion of therapeutic intent in ERCPs of grade 1 and 2 complexity. This should be achieved without any trainer assistance in ≥80% of cases by the end of training, and before a mentored period of practice.	Low	Strong
1.8 When performed by trainees, ERCPs of grade 3 and 4 complexity can be used to count towards lifetime procedure numbers and completion metrics, e.g. deep cannulation rates, but should be excluded from other key performance indicators (e.g. therapeutic success)	Very Low	Strong
1.9 Trainees should be able to demonstrate an overall 30-day post-ERCP pancreatitis rate of 5% or less of their Schutz 1 and 2 ERCP cases	Low	Weak
2.1 Trainees should be competent in diagnostic OGD and have experience of upper gastrointestinal endoscopic therapy before commencing ERCP training.	Very Low	Strong
2.2 Trainees should demonstrate the desire and commitment to practice ERCP at consultant-level	Very Low	Strong
2.3 It is desirable but not mandatory for trainees to train in both ERCP and Endoscopic Ultrasound (EUS)	Very Low	Strong
2.4 For ERCP certification, UK trainees are required to attend a JAG accredited basic ERCP course (with simulation and lectures) in the early stages of their ERCP training. JAG accredited intermediate and up-skilling courses are encouraged but not mandatory	Low	Strong
2.5 Trainees are recommended to use digital resources and attend live endoscopy courses and conferences to become familiar with ERCP techniques and accessories	Very low	Strong
2.6 Trainees are required to show evidence of attendance at HPB MDT meetings and contribute to the care of inpatients and outpatients with pancreaticobiliary disease	Very Low	Strong
2.7 Trainers delivering training in ERCP should have undertaken an endoscopy-specific train-the-trainers course	Very Low	Weak
2.8 All trainees should have evidence of experience of a minimum 300 ERCP cases prior to certification	High	Strong
3.1 Formative DOPS assessments during ERCP training should be used to track progression in technical and non-technical skills, and to support trainee feedback	Very Low	Strong
3.2 A formative DOPS should be performed regularly (i.e. at least 1 DOPS per every 10 hands-on training procedures during training) to provide objective evidence of skills acquisition and targeted feedback	Low	Strong
3.3 Self-assessment is an acceptable method of monitoring competency development which should be used in conjunction with objective assessment tools. Trainees should log all training procedures onto the JETS e-portfolio	Low	Strong
3.4 Trainees must demonstrate the following key performance indicators to be eligible for summative assessment for certification: - Complete stone clearance in 70% - stenting of distal biliary strictures 75% - native papilla cannulation rate 80% - Unassisted in 80% of cases in last 3 months (min 15 cases)	Very Low	Strong
3.5 Formative ERCP DOPS should be used in conjunction with other supporting certification criteria to assess eligibility for summative assessment. To undertake summative assessment, trainees should be rated as 'ready for independent practice' in ≥85% of the individual items of 5 recent formative DOPS (minimum of 3 DOPS on cases with a native papilla within the past 6 months), and with no items rated as requiring 'maximum supervision'	Low	Strong

3.6	For successful completion of the summative DOPS assessment, the trainee should be rated as 'ready for independent practice' in all items within 2 DOPS, by 2 different assessors, one of whom is not based at their current endoscopy unit	Very Low	Weak
4.1	Newly certified ERCP practitioners should have a defined period of mentorship lasting a minimum period of 2 years, with provisions available for regular progress reviews, e.g. at 3-month intervals	Very Low	Strong
4.2	The ongoing training requirements of newly accredited ERCP practitioners should be identified and should be encouraged to attend further training opportunities, e.g. upskilling courses	Very Low	Strong
4.3	Clinicians who have recently certified in ERCP should have systems in place to ensure appropriate case load selection: regular vetting of cases or through weekly HPB MDT/triage meetings	Very Low	Strong
4.4	There should be appropriate mechanisms in place for performance monitoring and review during the agreed transition period, e.g. at 3-monthly intervals	Very Low	Strong

for ERCP certification: 1) performing ≥ 300 hands-on procedures; 2) attending a JAG-accredited ERCP skills course; 3) in modified Schutz 1-2 procedures: achieving native papilla cannulation rate $\geq 80\%$, complete bile duct clearance $\geq 70\%$, successful stenting of distal biliary strictures $\geq 75\%$, physically unassisted in $\geq 80\%$ of cases; 4) 30-day post-ERCP pancreatitis rates $\leq 5\%$; 5) satisfactory performance in formative and summative direct observation of procedural skills (DOPS) assessments.

Conclusion JAG certification in ERCP has been developed following evidence-based consensus to quality assure training and to ultimately improve future standards of ERCP practice.

PTU-82 TIME TO TACKLE TRANSITION TRAINING IN GASTROENTEROLOGY: RESULTS OF A UK SURVEY

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Introduction Inadequate transition for chronic health conditions is associated with poor disease outcomes. The training of health care professionals in developmentally appropriate healthcare in the United Kingdom (UK) has not been measured. This national survey explores experience of Adolescent and Young Person (AYP) dedicated training and service delivery, from both adult and paediatric perspective.

Methods A 30-item 'SurveyMonkey®' questionnaire was developed by the British Society of Gastroenterology (BSG) AYP committee. This was emailed by the BSG and British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN) to its member trainees and those within five years of Consultant appointment, between June-September 2020.

Results Of 70 respondents, 71.4% were senior trainees or ≤ 5 years post CCT, with 54% being female. AYP training was not accessible to 58% in their current or most recent post. Of those that had prior AYP training, the majority (39%) had been to transition clinics. A fifth felt 'at least confident' that training offered adequate experience of AYP training. Nearly half of respondents wanted AYP specific training.

Significant barriers to AYP training (figure 1) and delivery were reported including lack of resources (60%), issues with funding e.g. who pays for the service (52%) and a lack of local interest in service development (46%).

Important patient related factors for successful transition were reported as ability to take medications unsupervised, patient understanding of disease and treatment.

Do any of the following barriers to AYP training apply to you?

Abstract PTU-82 Figure 1 Barriers to AYP training: responses

Health care related barriers to successful transition (1=lowest importance, 4=highest importance), were lack of time/space to set up joint clinic (3.12), lack of support services (3.04) and lack of funding (3.01).

Conclusions This cross-society national survey has revealed AYP training is extremely limited and the majority of respondents perceive inadequate experience and confidence in this area, despite there being a demand for change. AYP service delivery is widely varied with lack of resources, funding and interest as key healthcare related barriers. A concerted expansion both at national curricula development level and in individual departments is urgently needed, to advance exposure and training in AYP Gastroenterology.

PTU-83 THE GASTROENTEROLOGY AND HEPATOLOGY HIGHER SPECIALIST TRAINEE WORKFORCE 2020 – THE ISSUES OUR TRAINEES FACE

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Introduction The COVID-19 pandemic has had a significant impact on workforce, morale and training. Even prior to this, there were considerable challenges facing gastroenterology training due to the shape of training initiative.

Methods The Medical Workforce Unit of the Royal College of Physicians (RCP) undertakes an annual census of higher specialist trainee (HST) physicians each December. Key issues affecting gastroenterology and hepatology trainees combined in the census and General Medical Council (GMC) data from 2012 – 2020 were examined.