controlled endoscopically in 0.6% of patients who subsequently required surgery. Time of endoscopy was not associated with mortality (p=0.840), however inpatients had a higher 30 day mortality than outpatients (8.7% vs 1.3%, p<0.0005).

Trainees performed more endoscopies in 2018 than in 2011 (22.9% vs 15% respectively) with no difference in mortality compared to consultants (p=0.72). Trainees were on average in specialty training year (ST) 6, but 41.4% of trainees were ST7. There was no association with year of training and mortality (p=0.146).

Conclusion There has been an increase in trainee experience of UGIB endoscopy since introduction of our training interventions, targeted at late years of training. The new training pathway will be four years as opposed to five and therefore it is likely to reduce the experience of trainees in managing UGIB which still has a significant mortality association. Our interventions have demonstrated that training can be improved with targeted approaches.

P402 SMALL BOWEL ENDOSCOPY: DO WE OFFER ENOUGH TRAINING?

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Background There are currently 12 centres offering device assisted endoscopy (DAE) in the UK and between 30–35 offering video capsule endoscopy (VCE). There is a paucity of data on those offering training. We therefore quantify the training provided in small bowel endoscopy (SBE) across the UK to assess future training requirements.

Methods Online surveys and targeted calls to SBE centres were conducted of all British Society of Gastroenterology members in the UK to establish whether they were in SBE training and what level of training was offered to them.

Results From 17 centres there were 22 responses from gastroenterology fellows, trainees and consultants (36.4%, 18.2%, 45.5% respectively). Of all responders, 95.4% were independent in gastroscopies and 90.9% colonoscopies.

Training centres:

In total, 86.4% of centres offered VCE with 3 (IQR: 2–4) endoscopists per site interpreting videos. DAE was available in 72.7% of centres performed by 2 endoscopists (IQR: 2–3) per centre. Single and double balloon endoscopy was performed in 64.7% and 35.3% respectively under conscious sedation, deep sedation and both (35.3%, 29.4%, 35.3% respectively).

Training in video capsule endoscopy:

VCE was interpreted by 63.6% of responders of which 78.6% were independent. 31.8% of responders were undergoing training in both VCE and DAE, 36.3% in VCE and 9.1% in DAE. Of those who did not regularly review VCE, 75% were interested in becoming proficient.

Physicians required 50 (IQR: 20–50 videos) VCEs to gain competency. All physicians were confident in identifying pathology. To become independent, 50 videos (IQR 25–70) were reviewed. Responders who had attended VCE courses felt more confident in identifying pathology (100% vs 33.3% p=0.002).

Training in device assisted endoscopy:

Only 36.4% of individuals undertook DAE of which 75% were independent. However 42.9% were interested in becoming proficient. On average, participants completed 55 (IQR: 19–85) procedures prior to being independent taking 12 months (IQR: 6–27 months). The target lesion was reached in 50–100% of cases. All DAE trainees performed therapeutic procedures. Moderate to severe pain was reported in 10% of patients under conscious sedation and no sedation related complications reported. The learning curve for antegrade DAE was easier than retrograde DAE. The terminal ileal intubation rate during retrograde DAE varied from less than 50% to greater than 90%.

Conclusion Training offered in SBE is heterogenous with individuals having different levels of prior experience. There is a need to offer and formalise VCE and DAE training to ensure uniform competence. However, centres must have set requirements to achieve prior to being able to offer training to ensure the training offered is up to standard.

P403 OUTCOMES FROM THE SECOND IMPROVING SAFETY AND REDUCING ERROR IN ENDOSCOPY (ISREE) WORKSHOP

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Introduction The JAG 'Improving Safety and Reducing Error in Endoscopy' strategy was created to improve patient safety in endoscopy. A one day ISREE workshop was held to deliver

Abstract P403 Table 1

Domain	Statement	Pre-Workshop median	Post-Workshop median	*p* value
1	I have an understanding of the ISREE strategy and how it reflects safety in my area of work	5	9	**<0.01**
2	I am aware of the 'case of the month' series and understand how it can be used to share learning	8	10	**0.03**
3	I understand the elements of the safety domain of the GRS and how ISREE complements this	6	8	**0.02**
4	I have an understanding of how endoscopy patient feedback is utilised for safety-related training	5	8	**0.01**
5	I have an understanding of how incident reporting occurs across UK endoscopy services	5	8	**0.01**
6	I am aware of current human factors endoscopy training strategies being developed in the UK	4	9	**<0.01**
7	I understand how JAG is utilising technology to support learning from incident	5	8	**0.01**
8	I am confident in my knowledge of strategies to detect and support underperformance in endoscopy	6	8	**<0.01**