

to be insignificant and this has continued to be the case with adequate delivery of research project timelines and adequate annual progression reports from the academic supervisor. The education fellow post has been extremely well received. Feedback from 92 students (47%, 40% and 13% in yrs 2, 3 and 4 respectively) reported that 91.3% graded induction as high quality, 90% felt frequency of teaching was adequate, 98% were able to attend all or most of the supervised teaching sessions organised, 98.9% felt teaching sessions were good or excellent and most importantly 90.2% of students rated our placement $\geq 8/10$. The fellow and the team have received a letter of commendation from the University. The OOPR trainee has applied for an additional qualification of Fellow of the Higher Education Authority thereby facilitating future roles in medical and gastroenterology education and in improving the trainee's CV.

Conclusions One day a week education fellow roles within OOPR are viable and offer a significant opportunity to reduce the negative financial impact of taking time out from training whilst significantly improving gastroenterology undergraduate training programs in hospital and offering an opportunity to achieve additional training qualifications. We hope this will serve to attract high quality trainees to the higher specialist gastroenterology training programs by laying an attractive gastroenterology foundation in undergraduate years and high quality trainees to OOPR placements.

REFERENCES

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P400

THE FIRST REVERSE MENTORING IN A CLINICAL SETTING: CAN YOU TEACH OLD DOGS NEW TRICKS?

Suneil A Raju*, Hey-Long Ching, Mustafa Jalal, Michelle Lau, Anupam Rej, Foong Way David Tai, Gloria Tun, Andrew Hopper, Mark E McAlindon, Reena Sidhu, Mo Thoufeeq, David S Sanders. *Academic Unit Of Gastroenterology, Sheffield, UK, Sheffield, UK*

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Background The BSG offers a mentorship programme aimed at those in transitional phases of their career and less at experienced consultants. Reverse mentoring, the act of junior persons mentoring seniors, has gained traction in non-healthcare settings as a means of closing the gap between Boomers and Millennials. There is no data on applying this to a medical workforce. We present the first data of real clinical experience.

Methods A mixed-methods feasibility study on the practicalities of reverse mentoring complete in two phases.

Phase 1: all clinical fellows in a teaching hospital were invited to provide feedback in a group semi structured interview on their supervisors in 7 domains: use of technology, clinical practice, approach to juniors, time management, approachability, strengths and areas for improvement.

Phase 2: information was fed back to consultants on a 1-2-1 basis with the opportunity to discuss the points raised.

Pre and post mentoring questionnaires were collected. Likert scales were used to assess several aspects on a scale from 0 to 35 and thematic analysis to record participants thoughts.

Results A total of 6 clinical fellows participated in the phase 1 feedback session (66.6% male, age range 31–40 years) and agreed to be mentors. All supervising consultants invited

agreed to being mentees (80% male, age range 35–65 years) and have been consultants for 5–20 years. Mentoring sessions lasted 45 minutes (range 28–180 minutes) and all felt the time devoted was about right.

Both mentors and mentees reported a good or excellent experience. Juniors became more confident in feeding back to seniors after the session (21vs 31, $p=0.008$) and had a greater understanding of their role as reverse mentors (2.5/5 vs 4/5, $p=0.024$). Seniors became more aware of how they were viewed after mentoring (25vs 32, $p=0.04$). All seniors felt this was a useful experience that will change their clinical practice and 80% reported less concern about reverse mentoring afterwards. All participants believed that feedback was important both prior to and after the study (31 vs 33, $p=0.196$)

Common themes highlighted included the benefit of a different perspective to the norm and new ideas which can be implemented. There were concerns raised of the power gradient preventing effective mentoring and risks to relationships, however these were expressed as potential concerns and not experienced.

Conclusion The experience of all participants in this feasibility study were positive supporting the benefits of reverse mentoring in a healthcare setting. Junior doctors became better equipped to be future mentors. Consultants were given a new perspective which inspired them to improve their clinical practice and work environment.

P401

IMPROVING THE SHAPE OF TRAINING: AN INTERVENTIONAL STUDY ON UPPER GASTROINTESTINAL BLEEDS TRAINING

Sebastian Adu-Tei, Lauren JS Marks, Mohamed Daoub, Nishchay Kakkar, Edwin DA Bevis, Mohamed G Shiha, Hey-Long Ching, Suneil A Raju*, Mo Thoufeeq, David S Sanders. *Academic Unit Of Gastroenterology, Sheffield, UK, Sheffield, UK*

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Background There are growing concerns that UK gastroenterology trainees are not sufficiently exposed to endoscopic procedures. A recent publication by BSG trainees has shown Shape of Training will present new challenges in delivering endoscopy training within a shorter period. Our centre has previously identified significant reductions in training opportunities so introduced 3 new interventions: immersive training blocks, 'tailored to the trainee' endoscopy lists and ad hoc 'buffer' lists. We present the first data assessing how upper gastrointestinal bleeds (UGIB) training may change and compare the effect out intervention has had on the training experience.

Methods A retrospective review was undertaken of all patients investigated for UGIB at a tertiary teaching hospital specialist UGIB unit between January 2018 and May 2019. Comparisons were then made against training opportunities in 2011.

Results In total, 1059 patients were investigated for UGIB (mean age 62 years, SD ± 19 years, 75% as in patients) and 32.7% were taking anti-coagulants or anti-platelet medications. Patients underwent endoscopy during weekday working hours, weekday out of hours and weekends (67.7%, 18.3%, 14% respectively). The rebleeding rate was 16.5% and 30 day all-cause mortality 6.7% of which 15.5% were due to UGIB. The most common findings were gastritis, oesophagitis and peptic ulcers (27.3%, 22.9% and 19.0% respectively). UGIB was treated most commonly by adrenaline injection 9.3%, clips 7.3% and thermal therapy 4.9%. Bleeding could not be

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?

Suneil A Raju*, Stefania Chetcuti Zammit, David S Sanders, Reena Sidhu. *Academic Unit Of Gastroenterology, Sheffield, UK, Sheffield, UK*

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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

^{1,2,3}Srivathsan Ravindran*, ²Manmeet Matharoo, ¹Tim Shaw, ¹Eva Lynch, ¹Raphael Broughton, ^{1,2,3}Siwan Thomas-Gibson. *Joint Advisory Group on Gastrointestinal Endoscopy (JAG), Royal College of Physicians, London; ²St Mark's Hospital; ³Imperial College London*

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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