Method: 359 trainees across all subspecialties and UK regions were surveyed in 2011 regarding ISCP, compared to 539 users surveyed in 2008. A 5-point scales were analysed using chi-squared tests.

Results: 78% used ISCP, 38% elogbook and 5% CAP. 201 responders (56%) evaluated ISCP v8. 59% had registered before 2008 and 31% since. Modal ratings were ‘average’ throughout, with the following percentages of responders rating ‘poor’ or worse versus ‘good’ or better the domains: registration 12% vs 35%; assessments 36% vs 22%; peer assessment tool 34% vs 25%; recording meetings 34% vs 19%; helpdesk 11% vs 40%. Trainees were neutral about training impact and 44% thought ISCP was needed. Statistically significant ($p<0.001$) improvements were seen in satisfaction throughout domains comparing v8 to v5.

Conclusions: While satisfaction with ISCP has improved significantly during the last 3 years and its registration and helpdesk support are considered good, its assessment and meeting recording features remain average or worse. Increased satisfaction and ISCP’s perceived necessity may reflect an increased proportion of respondents who commenced training after its introduction.

0697: PRESCRIBING FOR SURGICAL PATIENTS COMPARED TO OVERALL PRESCRIBING SKILLS OF FOUNDATION YEAR 1 DOCTORS: A STUDY BY THE AVOIDING PRESCRIBING ERRORS (APE) COMMITTEE

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Aim: Prescribing errors are the most common type of medical error. Foundation Year 1 doctors (FY1s) are, according to recent research (1), responsible for 37.8% of these. We aimed to assess, using a validated instrument, the probability of wrong prescribing in common surgical medications (analgesia, antibiotics, anticoagulation) among FY1 doctors.

Methods: When starting in Croydon University Hospital, FY1 doctors take a prescribing test. We analysed 195 tests (over a period of 5 years). The 13 questions in this test were analysed to identify areas for improvement by an Avoiding Prescribing Errors (APE) committee which convenes monthly, led by FY1s supported by senior doctors and pharmacists.

Results: Logistic regression showed a statistical significant difference between cohorts in prescribing of opioids (41% correct answers, $p=0.001$) and penicillins (73% correct answers, $p<0.001$) but not warfarin (89% correct answers, $p=0.34$). Correlation coefficients were $r=0.59$, $r=0.30$ and $r=0.34$ respectively. There is a significant difference between pre-2010 cohorts (when formal prescribing skills teaching was implemented in medical schools, following the EQUIP study) and later cohorts.

Conclusions: There is no difference in prescribing skill in surgical medications and overall prescribing skill. Between cohorts, there is an improvement after 2010.


0700: HOURS AND SURGICAL TRAINING: THE ELEPHANT IN THE ROOM LIVES ON

Benjamin Dean, Erlick Pereira, Phil Duggleby. High Wycombe General Hospital, High Wycombe, UK

Aim: Our aim was to assess the current impact of working hours on surgical training and explore ways in which any problems may be addressed in the future.

Method: 359 trainees across all subspecialties and UK regions were surveyed in 2011 regarding working hours.

Results: A majority of respondents worked in excess of the legal 48 hour limit (81.1%) with the majority of these working in the 48-60 hour (57%) and 60-70 (36.6%) hour brackets respectively. The most common reason was to gain sufficient training exposure (48.2%), followed by service commitments with no rota gaps (28.1%) and service commitments due to rota gaps (12.5%). The vast majority of trainees were prepared to work extra hours (93.2%). The most frequent responses were 48-60 hours (39.9%) and 60-70 hours (31.1%).

Conclusions: The survey results confirm that the vast majority of surgical trainees would be willing to work extra hours beyond the artificial 48 hour limit, and a large number are already working extra hours in order to obtain adequate training. Increasing hours to a happy medium of around 60 hours per week in combination with improving the regulated training content of jobs appears a workable solution to the EWTD conundrum.

0706: A QUANTITATIVE ANALYSIS OF YOUTUBE AS A RESOURCE FOR SURGICAL EDUCATION

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Aim: To assess the availability of Youtube videos for each surgical specialty PBA.

Method: A list of the PBAs for all 9 surgical subspecialties was extracted from www.iscp.ac.uk. Search terms were derived from the PBA titles for each procedure excluding potentially nebulous terms. Youtube searches were conducted using the derived terms and the number of video results was recorded. The results were recorded as an analysed in Microsoft Excel.

Results: 92.6% of PBAs were available online. Specialties were ranked according to video/procedure. The top ranked subspecialty was OMF Surgery (875.5 videos/procedure), the lowest total number and the highest number of procedures with zero videos was Urology (35.6 videos/procedure; 8/53). The breadth of General Surgery included overlap with other specialties and may have affected their ranking. The T&O curriculum is completely covered (20853 videos, 100% PBAs).

Conclusion: There is a wealth of surgically based educational videos on Youtube. These videos represent a new, valuable and potentially under-used learning resource. Videos can aid teaching of surgical technique and we encourage sharing of good techniques, though qualitative studies will need to be completed. The relative lack of material in otorhinolaryngology provides an opportunity for surgeons to expand their teaching portfolio via video production.

0715: THE QUALITY OF BLOOD TRANSFUSION DOCUMENTATION AND CONSENT IN SURGICAL PATIENTS AT A CENTRAL LONDON TEACHING HOSPITAL. WHAT SHOULD WE BE TEACHING TO MAINTAIN GOOD TRANSFUSION PRACTICE?

Perbinder Grewal, James Neffendorf, Bryn Williams. Royal Free Hampstead NHS Trust, London, UK

Introduction: Accurate record keeping is a crucial component of good medical practice and blood transfusion documentation in surgical patients is essential for patient safety. There are also concerns about the level of information and consent of the patients. This study assesses the adherence to standards and quality of medical records on blood transfusion and the level of consent obtained.

Methods: We analysed the records for 108 transfusions performed at a Central London Teaching Hospital. All the patients were asked whether they gave written or verbal consent prior to transfusion of packed red cells and whether they received a blood transfusion information leaflet.

Results: Of the 108 patients, pre-Hb was documented in 65 patients (60.2%), indication in 38 (35.2%), consent in 2 (1.85%) and post-Hb in 48 (44.4%). Verbal consent was gained in 27% and leaflets were received by 4%. Conclusion: We have shown the quality of blood transfusion record keeping and consenting to be poor. This has major safety and legal implications, exacerbated by the EWTD and the ever increasing number of patient handovers. We propose compulsory transfusion teaching to include record keeping and consenting as an education tool for junior doctors. In addition, provision of leaflets must become routine.

0728: TEAM-BASED STRUCTURE WITHIN DEPARTMENT INCREASES TRAINING OPPORTUNITIES FOR JUNIOR TRAINEES

Henrietta Poon, Richard Thomson, Jill Webb. Queen Elizabeth Hospital, Birmingham, UK

Aims: Service provision and training of junior surgeons is a difficult balance. Working hours are limited by European Working Time Directives (EWTD). We implemented a change to the plastics surgery department senior house officer (SHO) rota to allow trainees to work in a consultant team-based structure; in order to maximise training opportunities and meet the learning requirements set by the Joint Committee on Surgical Training (J CST). The aim of this study is to assess if this change has improved learning opportunities for senior house officers (SHOs) in plastic surgery.

Methods: Retrospective review of the weekly rota for three weeks before and after the change implementation. The number of theatre sessions and outpatient clinics attended by SHOs was recorded.

Results: Four core trainees (CT), two foundation year 2 (F2) and two junior specialty doctors (JSD) were included in the study. Prior to the change; eight
SHOs attended 111 theatre sessions, 27 clinic sessions and spent 61 days on ward cover duties. With the new team-based structure, SHOs attended 189 theatre sessions, 55 clinics and spent 10 days on ward cover duties.

**Conclusions:** A consultant based team-based structure within plastics surgery optimises the balance between service provision and training opportunities for SHOs.

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**0754: THE ANATOMICAL KNOWLEDGE OF HEALTHCARE PROFESSIONALS REFERRING TO A HAND TRAUMA CENTRE**

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**Introduction:** Approximately 20% of all A+E presentations are hand injuries which equates to 1.36 million attendances per year in the UK. These injuries range from simple lacerations to mangled hands. Accurate descriptions of the injuries over the telephone are essential, this relies on a basic level of anatomical knowledge of the hand and we undertook a study to assess this.

**Method:** Every professional that referred a patient with a hand injury was asked 5 questions regarding hand anatomy. We felt that the level of questioning reflected knowledge that a final year medical student should possess and we tested this on a subset of them. We stopped when we had 50 answers from each set of referrers.

**Results:** A+E registrars scored a mean of 4.6 questions correct; their senior house officer counter-parts scored a mean of 3.2. Medical students scored a mean of 3.8 and emergency nurse practitioners scored a mean of 2.8.

**Conclusions:** We found that the level of anatomical knowledge in some practitioners was worse than in some medical students. We have formulated posters highlighting basic hand anatomical structures and have distributed them in order to ensure that our patients get the best possible treatment.

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**0761: DOES THE SENIORITY OF OPERATING SURGEON INFLUENCE THE LENGTH OF STAY AFTER LAPAROSCOPIC APPENDICECTOMY?**

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**Aims:** To assess factors influencing the outcome after laparoscopic appendicectomy, with particular emphasis on the seniority of surgeon.

**Methods:** A consecutive series of patients who underwent laparoscopic appendicectomy between April 2010 and April 2011 were studied. Data was collected retrospectively from computerised operating theatre and histopathology records. The primary outcome measure was length of hospital stay (LOHS).

**Results:** 118 patients [median age 29 (12-81), male:female 43:75] underwent laparoscopic (n=99) or laparoscopic converted to open appendicectomy (n=18). The lead surgeon was a Core Trainee or junior SpR in 44 (37.3%) and senior SpR or consultant in 74 (62.7%). The median LOHS was 2 days (1-34). On univariate analysis the following were significantly associated with a longer hospital stay: older age (p=0.001), longer duration of procedure (p=0.001), converted to open (p=0.006), more advanced appendicitis macroscopically (p=0.0001) and histopathologically (p=0.011). Time of day of surgery (p=0.078), delayed surgery (p=0.527), gender (p=0.284) and grade of surgeon (p=0.490) were not significant. On multivariate analysis only age (HR 0.987, 95% CI 0.94-1.00, p=0.046) was independently and significantly associated with LOHS.

**Conclusions:** There was no association between the seniority of the lead surgeon and LOHS. With adequate supervision laparoscopic appendicectomy remains an appropriate training operation for surgical trainees.

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**0776: A TOOL TO MEASURE SURGICAL DECISION MAKING IN ACUTE ADMISSIONS**

Zita Jessop, Michael Charalambous, Nebil Behar. Chelsea and Westminster Hospital, London, UK

**Aim:** Design a decision making tool to measure decisions by trainees, evaluate the degree of concordance with seniors and effect on patient outcomes.

**Method:** A decision making tool (10 management options), based on NCEPOD grading, was introduced into surgical clerking and completed at SHO, registrar and consultant level. Data collected on final diagnosis, delay to operation, hospital stay, complications and mortality. Two doctors independently derived “ideal decisions” based on final diagnosis.

**Results:** Decision making tool was completed for 136 acute surgical admissions over two months. SHO’s made less “ideal decisions” compared to registrars (45% vs 56%, p=0.10, Fisher’s Exact Test) and consultants (45% vs 70%, p=0.0001). SHO’s made more “admit and observe/investigate” decisions compared to registrars (63% vs 55%, p=0.27) and consultants (63% vs 51%, p=0.01), who were more likely to decide to “operate/discharge”. There was less time to appendicectomy (21 vs 14hrs, p=0.30) and shorter hospital stay (4 vs 3 days, p=0.31) but neither was statistically significant.

**Conclusions:** Results show that as you progress up the grades there is narrowing of decision making, with seniors more likely to decide to operate or discharge patients. This may reflect a combination of better decision making skills, demonstrating the value of early senior review, and increased availability of results.

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**0791: WHY WOULD STUDENTS CHOOSE A CAREER IN SURGERY IF WE NEVER LET THEM TRY IT? A SURVEY OF PROCEDURAL EXPERIENCE IN GRADUATING MEDICAL STUDENTS**

Nick Baylem, Matthew White. Queens Medical Centre, Nottingham, UK

**Aim:** One of the greatest draws to surgery as a career is the satisfaction achieved by completing a complex practical task successfully. In order to attract medical students to careers in surgery, it is important to give them a taste of this. The aim of this study was to assess the number of students being allowed to perform a simple surgical task on real patients.

**Methods:** An anonymous questionnaire was distributed to 323 graduating medical students. They were asked on how many real patients they had been allowed to suture. They were also asked to rate the major barriers to gaining more procedural experience at medical school.

**Results:** 203 questionnaires were received; a response rate of 63%. 39.7% of students had not sutured a real patient. Only 10.8% of students had sutured more than 5 times. The most commonly quoted barriers to more procedural experience were lack of on-call time and lack of enthusiasm in supervising doctors.

**Conclusions:** Allowing nearly 40% of medical students to finish medical school without performing such a simple surgical procedure will not help to entice them about a career in surgery. Medical schools and surgical trainers need to be proactive in remedying this situation.

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**0811: SHOULD UROLOGY BE A COMPULSORY PART OF GENERAL SURGICAL TRAINING?**

Steven Pengelly, Aled Jones, Michael Fabricius, Paul McInerney, Anthony Lambert. Derriford Hospital, Plymouth, UK

**Background:** We aimed to determine how much of the emergency take comprises urological patients and whether general surgeons receive appropriate training to manage them.

**Methods:** A prospectively recorded database of one consultant’s emergency admissions was examined to determine what proportion was for urological pathology. The ISCP website was interrogated to see what urology competencies are required during basic surgery training. Trainees were questioned regarding their urology exposure.

**Results:** 5959 patients were admitted with emergency surgical problems between June 2000 and December 2010, with 887 (15%) for urological pathology. The ISCP website was interrogated to see what urology competencies are required during basic surgery training. Trainees were questioned regarding their urology exposure.

**Conclusions:** Urological pathology makes up a significant part of the general surgery take. Trainees who have not had formal urology training are not achieving the required competencies laid down by ISCP. Urology should be a compulsory part of basic general surgical training.

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**0815: LEARNING CURVE IN SINGLE-PORT APPENDICECTOMY: AN EXPERIENCE FORM A UNIVERSITY TEACHING HOSPITAL**

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