**Conclusion:** We document a decline in the opportunity for trainees to perform open inguinal herniorrhaphy following the introduction of local treatment centres. Dedicated training lists have significantly helped address this problem and improved teaching in our area.

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**1117: BOOT CAMPS – THE FUTURE FOR SURGICAL TRAINING?**


**Introduction:** The need for a comprehensive induction programme for trainees starting each job is an essential requirement for effective training, patient safety and GMC guidelines. This is particularly true during national handover dates. Intensive, simulation rich training environments, or Boot Camps, have been suggested as one way to fulfil these requirements and ensure a high quality, educationally robust training opportunity.

**Method:** HESW Severn School of Surgery have now completed three regional boot camps for core trainees and first year general and orthopaedic specialist trainees. All participants were asked to complete a pre and post course survey based upon their previous experiences, value of the boot camp programme and their perceived benefits.

**Result:** Overall, all trainee enjoyed the boot camp experience and would recommend it as a way of inducting future trainees. The 2 or 3 day programmes were each tailored to the specific specialty and they each showed significant self perceived ability and confidence in technical and technical skills whilst trainees also highlighted the benefits of developing a collegiate and peer support network.

**Conclusion:** Surgical Trainees value the use of boot camps as an induction tool and may have a positive impact on patient safety and surgical training.

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**1128: MISSED TRAINING OPPORTUNITIES IN OPEN AND LAPAROSCOPIC INGUINAL Hernia repair**

C. Slawinski, N. Heywood, P. Cooke, R. Basson, R. Fish, J. Barker, Collaborators of the NWRC Consent Audit, 1 Blackpool Teaching Hospitals NHS Foundation Trust, Blackpool, Lancashire, UK; 2 University Hospital of South Manchester NHS Foundation Trust, Manchester, UK; 3 East Lancashire Hospitals NHS Trust, Blackburn, Lancashire, UK; 4 Bolton NHS Foundation Trust, Bolton, Manchester, UK; 5 Salford Royal NHS Foundation Trust, Salford, Manchester, UK; 6 North West Research Collaborative, Manchester, UK.

**Aim:** A minimum of sixty inguinal hernia repairs are required for the certificate of completion of training. We aimed to assess utilisation of open and laparoscopic inguinal hernia repair cases for training in Health Education North West (HENW), UK.

**Method:** A retrospective review of primary inguinal hernia repairs at nine participating sites was performed. We assessed a random sample of operations undertaken between 1st August 2013 and 31st July 2014. A minimum of 50 cases were selected per site and the grade of the primary operating surgeon was determined by a review of the operation note.

**Result:** A total of 673 open and 347 laparoscopic inguinal hernia repairs were included in the analysis. The primary operating surgeon for each procedure (open vs laparoscopic) was as follows; consultant (54.2% vs 88.8%), associate specialist (12.2% vs 0.6%), ST3 trainee or above (15.3% vs 4.9%), Trust Registrar (11.1% vs 4.9%), core trainee (4.3% vs 0.6), foundation year 2 (0.2% vs 0%) and unknown (1% vs 0.3%)

**Conclusion:** Our results demonstrate that case availability does not limit training opportunities in HENW. However, questions are raised regarding case utilisation for training, the reasons for the observed operator mix and potential strategies to maximise training.

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**1167: THE EFFECTS OF MODERNISING MEDICAL CAREERS ON SURGICAL TRAINING**

J.W. Lim, Z.Y. Tew, D. Mittapalli, M. Lavelle-Jones, Foundation Doctor, NHS Tayside, Dundee, UK; 2 University of Dundee, Dundee, UK; 3 Department of General and Vascular Surgery, Ninewells Hospital, NHS Tayside, Dundee, UK.

**Aim:** To evaluate the effects of the Modernising Medical Careers (MMC) on surgical training.

**Method:** Retrospective data collection regarding the involvement of trainees as the main surgeon in both elective and emergency cholecystectomies before and after the introduction of the MMC in a university hospital.

**Result:** A total of 4803 laparoscopic and open cholecystectomies from 1999 to 2013 were reviewed. 414 cases were excluded due to lack of documentation. Of the 4389 cases, 2509 were elective cases whereas 1880 were emergency cases. Prior to the introduction of MMC, trainees were the main surgeons for 57% cases with 49% of electives and 67% of emergencies. Since the introduction of the MMC, trainees were the main surgeons for 45% cases with 39% of electives and 53% of emergencies; a total reduction of 13% (10% for electives and 14% for emergencies). The operation durations for consultants were longer, irrespective of the introduction of the MMC, suggesting that consultants were most likely involved in complex cases.

**Conclusion:** The implementation of the MMC has significantly reduced the surgical exposures for trainees as the main surgeon in both elective and emergency cholecystectomies, which may have an impact on training quality and operative skills.

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**1224: INDEX PROCEDURES FOR CCT: ARE THEY AN ACHIEVABLE TARGET FOR ALL?**

J. Chang, A. Sharples, A. Rotundo. University Hospital North Midlands, Stoke, UK.

**Aim:** JCST requirements for CCT indicate general surgical trainees need 100 laparotomies (20 segmental resections), 55 cholecystectomies, 60 hernia repairs and 80 appendicectomies.

We assessed opportunities trainees are given in a busy university hospital as well as our impact upon surgical operative times in CEPOD.

**Method:** All emergency general/vascular surgical cases performed between 01/04/15 and 31/10/15 were identified via hospital ORMIS system. Operative surgeon, times and operative details recorded.

**Result:** During the study period 1370 cases were performed; in 800 cases the operative surgeon was a trainee. Appendicectomy (OR 2.21; p<0.0001) and hernia repair (OR 2.66; p=0.0007) are most likely performed by consultants. Trainees are less likely performing laparotomies (OR 0.23; p<0.0001), segmental resections (OR 0.15; p<0.0001) or cholecystectomies (OR 0.38; p<0.0001).

Multivariate analysis controlling for NCEPOD “Urgent” cases; show trainees have lower mean operative time than consultants (71min vs 107min; p<0.0001), likely representing consultants input in more complex cases. In “immediate” cases no significant difference in operative time was seen between trainee and consultant (178min vs 110min; p=0.374).

**Conclusion:** Our analysis shows trainees most likely to struggle to achieve required number for laparotomies, cholecystectomies and colorectal resections. Focus on how to develop training in these areas needs to be considered.

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**1240: WHICH FACTORS INFLUENCE CAREER CHOICE? A MEDICAL STUDENT SURVEY**

C. Gelder, J. Selwyn-Gotha, M.J Rouhani, S. Rufai, Hull York Medical School, York, UK; 2 North East Thames Foundation School, London, UK; 3 North