challenging, necessitating a multidisciplinary team approach. Integrated care pathways are in widespread use but had not been previously assessed in the authors’ unit.

Design: A scoring tool was developed to assess the standards of record keeping based on guidance in Good Surgical Practice, 2008. A retrospective assessment of 14 sets of case notes was conducted. The results were used to develop a daily record keeping proforma for the multi-disciplinary team. Following implementation and re-audit, a two sample t-test was used to analyse the significance of the change in score. A questionnaire investigated the views of the MDT regarding record keeping.

Results: Mean scores increased from 22.2/50 to 42.7/50 (p<0.05) following the implementation of the tool. Of the nine members of the MDT questioned, all felt that head and neck record-keeping needed improving, primarily in MDT (9/9) and doctors’ (7/9) record keeping. All felt that MDT and doctors’ record-keeping, and inter-disciplinary communication, were improved by the tool.

Conclusions: This record-keeping tool is an effective means of improving record-keeping standards and inter-disciplinary communication, with implications for clinical and medico-legal aspects of patient care.

0421 DOES ONE SIZE FIT ALL? CANCER MDT WORKING ACROSS DIFFERENT TUMOUR TYPES
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Introduction: Multidisciplinary cancer teams (MDTs) must work to the same specifications regardless of speciality or location. Anecdotally, the workload of MDTs differs between specialities. Our aim was to identify similarities and differences between MDTs of different tumour types.

Methods: Data from the 2009 National Cancer Action Team survey covering MDT structure, clinical decision making, team governance, and professional development was analysed. 2054 respondents included doctors, nurses, allied healthcare professionals and administrators. Comparison was made between urology, breast, colorectal, lung, haematology, upper GI, gynaecology and head & neck MDTs.

Results: Consensus between tumour types was found across 75% of the domains assessed. There were no differences concerning MDT infrastructure, or team governance. There was major consensus regarding teamworking, MDT membership and MDT development. Differences between tumour types occurred regarding preparation and organisation for MDT meetings, and clinical decision-making process (all P<0.001, Mann Whitney U).

Conclusions: Many of the characteristics needed for effective MDT working are common to different specialities, implying that assessment and training tools may be universally employed. However, this analysis also identifies some areas that may require a tailored approach. In particular, members from all common tumour types expressed variation in some areas of teamworking and clinical decision making.

0424 IMPLEMENTATION OF A NURSE-LED CLINIC FOR ELECTIVE TONSILLECTOMY REFERRALS IN THE UK: PATIENT SATISFACTION OF THE SERVICE
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Introduction: Nurse-led clinics have been long established within ENT to tackle economic and staffing resources. For this reason, in 2006 a nurse-led ‘one stop’ pre-admission clinic was introduced in Lincoln County hospital, Lincoln. Subsequently, we conducted a study to assess whether the service was fulfilling patient satisfaction since the implementation of the clinic.

Materials and Methods: A prospective study was performed on patients who attended the clinic. Patients were contacted by telephone to participate in a telephone patient satisfaction survey. A proforma comprising of questions was used to ascertain patient satisfaction.

Results: All 23 patients consented to participate. Overall, all patients were happy about being assessed by a nurse. No patients felt unsatisfied about the outcome of the pre-assessment clinic. Most patients felt prepared for tonsillectomy. Areas patients were dissatisfied with the service was due to cancellation of the procedure and where a patient would have preferred to have seen a doctor prior to the procedure as means of reassurance to their family.

Conclusions: ENT nurse-led clinics deliver effective, safe and resourceful service provision. In regards to elective tonsillectomy, nurse pre-assessment clinics are regarded to offer good patient satisfaction. Therefore, they should be recommended.

0438 SYSTEMATIC REVIEW OF DAY-CASE LAPAROSCOPIC FUNDIPLICATION IN ADULTS
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Aim: This study reviews the published literature on day-case laparoscopic fundiication in adults.

Methods: Systematic search was performed in Medline, Embase and Cochrane library using the medical subjects headings (MeSH) terms “ambulatory surgical procedures” and “fundiication” with further free text search and cross references. All articles on day-case laparoscopic fundiication which described patient selection criteria, same-day discharge, complications and readmissions were reviewed.

Results: There were no randomised controlled trials. Thirteen cohort studies were included in this review. Of these 10 were on planned same-day discharge in adults with a 93.3% (739 out of 792 patients) success rate. 34 (4.29%) patients developed complications and 39 (3.08%) patients were readmitted. Three studies which looked at planned 23 hour discharge in adults reported a 97.94% (571 out of 583 patients) success rate with 25 patients (4.29%) developing complications and 5 patients (0.87%) being re-admitted. Nausea, pain, fatigue and pneumothorax were the commonest causes for overnight admission. Dysphagia and pain were the main reasons for readmission. Most patients were satisfied with day-case laparoscopic fundiication.

Conclusion: Laparoscopic fundiication seems safe and practical as a day-case procedure in adults. Outcome measures like postoperative pain, complications, readmissions and patient acceptability are good.

0440 THE 2-WEEK RULE FOR SUSPECTED HEAD AND NECK CANCER: CAN A ONE-STOP CLINIC APPROACH IMPROVE PATIENT SERVICES?
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Introduction: A number of groups have audited the 2-week wait for suspected head and neck cancer since its introduction in 2000. These studies have consistently shown that the referral criteria have a low pick up rate for malignancy and question whether they provide a benefit to the patient.

Aim: Assess the cancer detection rate for 2-week wait referrals and decide whether a one-stop clinic would be appropriate.

Method: A retrospective audit of all 2-week referrals from July 2009 to July 2010.

Results: Total 2-week-wait referrals =622; Confirmed malignancy= 35 (6%); Total malignancies between July 2009-July 2010= 143. Only 230 patients (37.0%) required a follow-up appointment of which 182 patients underwent further investigations. Only 93 patients (15%) underwent a FNA and 76 (12%) an ultrasound scan.

Discussion: Our study confirms that the majority of patients diagnosed with head & neck malignancy are referred through routine referral pathways. The limited need for FNA and ultrasound scans suggests that there is unlikely to be a significant benefit to patients or a more efficient use of resources by implementing a one-stop clinic.

0442 IS RESTORATIVE RESECTION RATE A TRUE QUALITY INDICATOR OF RECTAL CANCER SURGERY?
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Aim: To determine if restorative resection rates could be used as an indicator of quality of rectal cancer surgery.

Method: A retrospective study of all rectal cancer surgery procedures. Data were collected from case notes, discharge letters and hospital databases.

Results: A total of 150 rectal cancer procedures were included in the study. The overall restorative resection rate was 50%. There were no significant differences in patient demographics or tumour characteristics between those who did and did not undergo a restorative resection. There were no significant differences in clinical outcome measures such as hospital stay, complications and readmissions between the two groups.

Conclusion: Restorative resection rate is not a reliable indicator of quality of rectal cancer surgery.