and clinic findings in 37 patients (63%). The majority had further investigation (lower GI endoscopy or imaging). The commonest diagnoses were diverticulosis (44%) and benign polyps (22%) but 3 patients had CRC of which 2 had metastatic disease at presentation.

**Conclusion:** Most data from 2ww clinics show low rates of diagnosis of CRC, with little evidence of any improvement in prognosis. Low adherence to referral guidelines from primary care may be a factor. It is crucial that primary care providers are aware of the guidelines when referring to 2ww clinics.

**0435: READMISSION AFTER GENERAL SURGERY (RAGES)**

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**Aim:** Readmissions are undesirable for patients and carry financial penalties for hospitals where they occur within 30 days of discharge. The aim of this study was to determine the readmission rates and potential contributing factors within the South Yorkshire region.

**Methods:** A prospective region-wide audit was undertaken over two weeks, including all patients undergoing NHS-financed general surgery in the region. All patients were followed up for 30 days to identify readmissions. Demographics, procedure data including BUPA and CEPOD classifications and basic post-operative data were collected.

**Results:** One teaching hospital, 3 private providers and 4 DGH’s undertook 698 procedures in this period with 38 readmissions within 30 days (5.44%). Unit-level readmissions ranged from 0.02–11.7%. When preventable readmissions were excluded, the readmission rate was 3.29% (0.02–6.48%). There was no correlation between age, gender or comorbidities and readmission. The least deprived had a lowest readmission rates (p=0.02). There was no difference in readmission rates following planned or unplanned surgery. Readmission rates increased with complexity of surgery (3.45% minor vs 11.1% complex, p=0.05).

**Conclusion:** In our region, unavoidable readmissions follow 3.3% of operations. Readmission is associated with complexity of surgery and deprivation. There is unit-level variation which may reflect how re-tenders are managed.

**0438: A COLLABORATIVE STUDY PROPOSAL: TO ASSESS RATES OF UK POST-OPERATIVE PNEUMONIA (RAPP)**

T.M. Drake*, E.M. Nofal, M.J. Lee. On behalf of SYSuRG University of Sheffield, UK

**Aim:** Post-operative pulmonary infection is amongst the most prevalent complications following surgical procedures. Infections are associated with significant mortality, morbidity and heightened costs of hospital stay.

**Methods:** The proposed cohort study aims to establish the risk-adjusted incidence of post-operative pneumonia. As a secondary aim, variation in preoperative optimisation strategies will be investigated. There is scope for cross-speciality engagement. Patients undergoing elective surgery as an inpatient over a four-week period will be included. Risk of post-operative pneumonia will be calculated based on the POP score. Data will include; BMI, co-morbidities, operation, pre-operative optimisation, functional status and post-operative analgesia. The primary outcome will be rate of post-operative pneumonia, as defined by CDC criteria. Secondary outcomes will include length of stay and complication severity.

**Conclusion:** Further analysis will identify effective interventions for testing in randomised clinical trials.

**0445: SURGICAL WEEKEND HANDOVER: AN AUDIT TO IMPROVE STANDARDS WITHIN A TERTIARY HOSPITAL**

R. Radwan*, R. Chaytor, M. Gallagher, J. Barry, Morriston Hospital, UK

**Aim:** The implementation of EWTD has had a significant impact on working patterns for junior doctors. Effective clinical handover is vital to patient safety and high quality care. Our aim was to improve surgical weekend handover through the use of a standardised handover proforma.

**Methods:** Retrospective review of weekend handover (8 weekends). Handover sheets were scrutinized for 9 of the most important variables that should be included for any particular patient.

**Results:** A total of 525 patients. 4 variables (Job Plan, D.O.B, Bed Location, Supervising Consultant) had less than 50% Compliance. Only 1 variable (Patient Name) was filled out for all patients. A standardised handover proforma was devised and implemented containing all 9 required variables was implemented. A prospective re-audit of 8 weekends was then carried out. Re-audit Results: A total of 487 Patients. 8 variables in total had >99% documentation for handover. 1 variable (Bed Location) continued to have less than optimal compliance (76%).

**Conclusion:** The development of a standardised proforma has led to a significant improvement in weekend handover of surgical patients and should be common practice in all hospitals.

**0455: DOCUMENTING THE USE OF CHAPERONES DURING INTIMATE PATIENT EXAMINATIONS; ADHERENCE TO GMC GUIDELINES**

N. Sharma, L. Henderson, S. Bajgoric*, P. Buxton, A. Walsh, S. Rajagopalan. Royal Stoke Hospital, UK

**Aim:** To assess our documentation of the use of chaperones during intimate patient examinations using the GMC Guidelines on Good Medical Practice: ‘Intimate examinations and chaperones (2013).’

**Methods:** Prospective audit of all surgical, urological and gynaecological admissions on surgical assessment unit (SAU) over 1 week. Intimate examinations were defined as those pertaining to examination of the breast, genitalia, digital rectal (DRE) or per vaginal (PV). Case notes’ reviewed and data collected on a pro-forma.

**Results:** We collected data for 61 patients, M:25, F:36 with an average age of 55y(22y-90y). Breast: 1, genitalia:15, DRE:38 and PV:7. Of 61 patients receiving intimate examinations by doctors, 10(16.4%) had documentation of a chaperone being used and 9(14.75%) where the chaperone details were documented. 3 patients(4.9%) had the documentation of a chaperone being declined. 51 patients(83.6%) had no documentation pertaining to the use of or offer of a chaperone.

**Conclusion:** Lack of documentation does not equal absence of chaperone but suggests inadequacy of documentation. Meticulous documentation in this regard needs to be highlighted to all surgical specialties to protect patients from harm and offer medical-legal protection. We intend to redesign our surgical admission pro-forma to include a chaperone checkbox, to educate SAU clinicians and re-audit.

**0494: HEAD INJURY MANAGEMENT IN A DISTRICT GENERAL HOSPITAL: A FULL AUDIT CYCLE**

C. Zhang*, K. Prabhu, B. Tweedie, T. Newman, R. Thomas. Croydon University Hospital, UK

**Aim:** Head injury (HI) patients span a broad spectrum of clinical severity. Good communication at local and regional levels is necessary to monitor clinical deterioration and instigate appropriate treatments. Two patients with adverse outcomes led us to conduct a full audit cycle of local HI management.

**Methods:** Adult HI admissions under General Surgery from February–May 2014 were included in the initial audit (43 patients). With reference from NICE, we focussed on: indications for CT or admission; initial neuro-observations, and documentation quality of neurosurgical referrals. Findings were presented at Clinical Governance; a clerking template was introduced; and guidelines displayed in A&E and surgical departments. We re-audited from September - December 2014 on 36 patients.

**Results:** Post-intervention improvements were observed in the following domains: neuro-observations at presentation written in A&E or surgical clerking (from 7% to 25%); written EVM breakdown of GCS when <15 (from 7% to 22%); clear documentation of neurosurgical discussions and non-surgical management plans (from 32% to 75%). Use of clerking templates was however poor, attributable to doctors’ unfamiliarity with navigating our electronic documentation platform.

**Conclusion:** Written communications of HI patients’ salient clinical features can be improved through increased awareness of clerking and management guidelines.