Method: A retrospective analysis of patients at a London hospital with anal skin tag excision over five years was identified via electronic records. 266 patients were identified and histological analysis of the specimen sent on the date of operation was checked.
Result: One patient was identified as having a squamous cell carcinoma. 3 out of 175 where histology was available showed high grade AIN (either AIN 2 or AIN 3) and three had viral warts.
Results showed that 34.2% of patients did not have a histological result recorded.
Conclusion: 2.3% of anal skin tags excised over five years had a histological diagnosis of cancer or AIN. The detection rate of cancerous lesions in our population suggests that anal skin tag excision is of clinical value and that all specimens should be sent for histology. This analysis also showed that electronic coding for procedures could be improved. A further prospective study sending all specimens for histology is warranted.

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0301: ASSESSMENT OF PATIENTS' PSYCHOLOGICAL NEEDS ON THE COLORECTAL ENHANCED RECOVERY PROGRAMME AT A DISTRICT GENERAL HOSPITAL

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Aim: This audit aimed to assess local adherence to an aspect of NICE guideline CG138, on the colorectal Enhanced Recovery Programme (ERP). The guideline stipulates that patients' potential need for psychological support should be recognised and regularly reviewed. One aspect of this is the identification of pre-existing mental health problems.
Method: 30 patients who underwent colorectal surgery on the ERP in 2014 were identified. Their case notes were studied retrospectively to determine whether patients had been questioned pre-operatively about psychiatric co-morbidities or cognitive impairment.
Result: In only 2% of cases studied had patients been screened as described above.
Conclusion: This represents an unequivocal failure to recognise those at increased risk of needing psychological support in the peri-operative period.
The ERP proforma was altered to include a specific question about mental illness, as well as an Abbreviated Mental Test Score (AMTS) for patients 75 years and over. The proforma also now prompts regular completion of a Hospital Anxiety and Depression Scale (HADS) by those with pre-existing mental illness.
A re-audit of 30 cases subsequently demonstrated screening in 68% of cases. Further improvement is needed, and a larger study is desirable to determine what impact this intervention has on patient outcomes.

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0330: IMPROVING OUTCOMES: IMPLEMENTATION OF THE ASGBI PATHWAY FOR THE MANAGEMENT OF SMALL BOWEL OBSTRUCTION (SBO) AT THE ROYAL UNITED HOSPITAL

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Aim: Small bowel obstruction (SBO) is a surgical emergency accounting for 12–16% of acute surgical admissions across the UK and is responsible for 20% of emergency laparotomies[1]. The RCS Commissioning Guide produced a pathway to improve management of SBO[2]. We aimed to implement this pathway to facilitate conservative resolution of SBO, thereby mitigating requirement for unnecessary laparotomies.
Methodology: Initial data was collected retrospectively using clinical coding records over 4 months (n = 36), and cross-matched with theatre records for completeness. Outcomes were assessed in accordance with the different pathway stages. We implemented the 'initial pathway' then prospectively collected data over 2 months (n = 13). The pathway was then adapted to facilitate easier use amongst healthcare professionals, this included wider accessibility of gastrografin. We then re-audited (n = 14).
Result: Initial results demonstrated 75% (27/36) of patients underwent laparotomies with 25% (9/36) resolving following conservative management. Following pathway implementation, we observed a reduction to 46% operative resolution. Pathway amendments caused an increase to 57%, however conservative resolutions following gastrografin improved from 0%–14%. Laparotomy reduction shows statistical significance (z-score,one-tailed *t*-test $p < 0.05$).
Conclusion: Our findings provide evidence that through implementation of this pathway we have ameliorated our conservative management of SBO and subsequently reduced unnecessary emergency laparotomies.

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0358: USING CR-POSSUM TO PLAN HDU ADMISSIONS FOR HIGH-RISK PATIENTS UNDERGOING COLONIC RESECTIONS

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Aim: The 2011 Royal College of Surgeons and Department of Health guidelines state that all higher risk general surgical patients (predicted mortality ≥10%) should be admitted to critical care post operatively. CR POSSUM was used to classify patients as low (mortality<5%), intermediate (5–10%), or high-risk (>10%). Whether patients had planned or unplanned admissions to HDU post operatively was evaluated.
Method: All patients who underwent major colorectal cancer surgery from April 2013 to April 2014 were included. 103 patients met the inclusion criteria; notes were available for 90 patients.
Result: There were 31 patients with predicted a mortality >10%; Only 8 of these patients had HDU beds booked post operatively and there were 7 unexpected HDU admissions. Thirty five patients had a predicted mortality 5–10%, 6 of whom had HDU beds booked post operatively. There were a further 6 unplanned HDU admissions in this group.
Conclusion: CR POSSUM is a user friendly pre-operative assessment tool to estimate mortality risk. Only a fraction of our high risk patients are routinely managed in HDU post operatively. The number of unplanned HDU admissions could be reduced by developing our pre-operative assessment system to identify patients who would benefit from HDU care post operatively.

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0397: DO RESOURCES AFFECT OUTCOMES IN COLORECTAL SURGERY? RESULTS OF A NATIONAL SURVEY OF UK UNITS

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Background: Resource levels are thought to be associated with surgical outcomes. The ACPGBI has undertaken a survey of UK colorectal units to assess this.
Method: Data was extracted from hospital-level surveys of UK colorectal surgery units. This assessed domains of care including inpatients, outpatients, endoscopy and nursing. This was correlated with HES data on 90-day mortality, 90-day readmissions and CEPS global rating. Centres were grouped by the primary outcomes of adjusted 90-day mortality rate, readmission and overall patient satisfaction using a hierarchical euclidean distance-based clustering algorithm. Variation in resource levels were compared between clusters with univariate poisson analysis.
Result: 91 of 175 UK mainland trusts responded. Variation in end-points for HES data meant Welsh and Scottish units were excluded. This left 75 responses from hospitals undertaking colorectal surgery across England. This algorithm split centres into three tiers of outcomes; poorer outcomes (8.3% mortality, 19.4% readmission, 87.7% satisfaction), middle outcomes (4.2% mortality, 21.5% readmission, 88.2% satisfaction) and better outcomes (2.0% mortality, 17.3% readmission, 89.7% satisfaction). Analysis of population served, workload, consultant and nurse staffing levels did not show significant variation between clusters.