Social and Health education (PSHE) across schools. The mental health of young people is a growing challenge for doctors. Many of the root causes of mental health problems are societal and can only be addressed with a truly multi-disciplinary approach. Doctors should take the lead in communities, whether volunteering as school governors or in lobbying for a standardised PSHE curriculum.PSHE can empower young people to seek help with their mental health. Teachers are often the first to notice a decline in a student's mental health. Consequently, channels of communication between teachers and doctors should be strengthened, with healthcare expertise and educational excellence combining to improve early intervention for mental health problems.

Call for posters – leading innovation and improvement

55 TREATMENT ESCALATION AND RESUSCITATION DECISION-MAKING AT MEDWAY FOUNDATION TRUST

[1]Abbi Graham*, [1]Jordan Ellis, [1]Shivaani Yogalingam, [1]Priyancaa Jeyabaladevan, [1]James Rogers, [2]Michael Fadel, [2]Priya Krishnan, [2]Krishan Parekh. *[1]King's College London University, UK; [2]Medway Foundation Trust, UK*

10.1136/leader-2018-FMLM.53

Background At Medway Foundation Trust, an audit reviewing resuscitation decision-making revealed we had to be more decisive with our DNACPR orders. This led to the introduction of Treatment Escalation Plan (TEP) forms. TEP forms ensure that every patient has their ceiling of care discussed and documented formally.
Aim Our aim was to improve TEP documentation through developing a revised and concise form through our TEP working group of consultants.
Methods Plan-do-study-act (PDSA) cycles (100 patients per cycle across both medical and surgical wards) were carried out over a two-year period to evaluate whether TEP forms had been effective at improving escalation planning and DNACPR decision-making.
Results An improvement of 14% was seen with appropriate TEP form completion after the introduction of the revised TEP form. 75% of the forms were completed within 24 hours of admission, compared to 68% with the initial TEP form. There was a 16% increase in patient/relative discussion. In addition, there was a 13% improvement in resuscitation decision-making since the introduction of TEP forms and increased staff awareness surrounding patient's escalation plan.
Conclusion The revised TEP form led to fewer errors and an increase in documentation. The higher completion rates and increased clarity among staff have helped improve patient safety outcomes and communication between patients and staff members. However, we have still not yet reached our target of 100% TEP form completion within 24 hours. Our results demonstrated that many patients/relatives are not being included in these discussions and complaints were highlighted regarding inappropriate treatment escalation and resuscitation. These results have allowed us to develop interventions to combat these issues identified. A patient focused information leaflet and staff mandatory intranet training resource are currently in development, the impact will further be assessed in a further PDSA cycle.

Call for posters – leading innovation and improvement

56 RE-DESIGNING WORK SCHEDULES TO IMPROVE MORALE AND ENSURE HOURS SAFEGUARDS ARE MET

Emma Cox*, Vidushi Golash, Caroline Fertleman. *Whittington Health, London, UK*

10.1136/leader-2018-FMLM.54

Problem Surgical FY1s routinely exceeded their contracted hours. Some doctors were also rostered to work more hours than others, which was affecting teamwork and morale.

We reviewed the work schedules of surgical FY1s and found:

- Significant variation between contracted hours (range from 42 hours/wk to 46 hours/wk).
- Large discrepancies between contracted and rostered hours (2¼ hrs/wk on average amounting to an underpayment of £1,499.25 per annum).
- A fifth of work schedules contained a week of zero days timetabled to occur after the placement had finished.

As a result hours-safeguards were not being adhered to.
Intervention We presented our data to Human Resources and a corrective payment was issued. However we needed to address the unsafe working hours and unfair hours distribution between trainees. We consulted stakeholders and it was agreed to increase certain shift lengths. We then created generic work schedules, which were consistent in the average number of hours worked, the proportion of antisocial hours allocated and the salaries paid.
Results

- Variability in working hours between FY1s: no variation within each subspeciality, 30 mins/week variation between subspecialities. Previously: 4 hours/week variation between FY1s.
- Rota and work schedule concordance: 100% concordance. Previously: 0%.
- FY1s satisfaction: 100% of FY1s felt the new rotas more accurately reflected their working hours.

The changes resulted in: rota and work schedule concordance; an even distribution of shifts between trainees; and rostered hours that were reflective of the hours actually worked. Hours-safeguards were met and trainees were paid fairly. Trainees reported feeling more valued by the organisation, which improved morale and teamwork.
Lessons learnt There is generally a poor understanding of the 2016 Junior Doctor Contract, so there can be errors in its implementation. The most important lesson we learnt was that we can engineer significant change- even as an FY1.