Discussion There is evidence to show staff satisfaction has an impact on patient safety. We hope to improve local recruitment and retention by focussing on the wellbeing of the transient, but critical, workforce of junior doctors. In order to monitor impact an annual survey will be carried out. This is a challenging and multifaceted project requiring dedication, leadership and engagement from junior doctors, senior management, post-graduate departments and rota teams to name a few.

Developing effective leaders

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¹Eleanor Crossley*, ²Cassie Lawn, ²Nick Groves, ²Rob Galloway. ¹University Hospital Southampton NHS Foundation Trust, UK; ²Brighton and Sussex University Hospital Trust, UK

10.1136/leader-2018-FMLM.51

1) Context: In healthcare delivery, serious and critical incidents have demonstrated how human interactions can significantly compromise patient safety. This branch of study known as Human Factors is only recently being taught to healthcare professionals, despite widespread use in aviation and other industries.

A local consultant from an NHS teaching hospital introduced one-day Human Factors workshops for multi-disciplinary staff from different NHS Trusts across South-East England. The workshops were free-of-charge for attendees, with over 1000 attendees to date.

2) Issue: Human Factors teaching is still in its infancy; little is known about the effectiveness and transferability of this teaching into healthcare practice. Furthermore, little is known about which teaching methods and content are most powerful and relevant in delivering Human Factors education.

3) Assessment of issue and analysis of its causes: The workshop used incident reports from an NHS teaching hospital to illustrate how failings in Human Factors can contribute to errors in healthcare. It also emphasised that Human Factors teaching is relatively new in medical education; the challenge is therefore to improve staff awareness of Human Factors and its relevance in day-to-day practice.

Workshop attendees over a three-month period were therefore asked for their written consent to participate in individual semi-structured telephone interviews following the workshop. Consenting attendees were telephoned by one of two investigators two-to-six months after the workshop, at an agreed date and time.

4) Intervention: Forty-three workshop attendees over a three-month period participated in telephone interviews. Interviewees' key learning points identified five main themes: the importance of effective communication within teams; the need for a change in culture; the role of hierarchy and importance of speaking up; the impact of situational awareness; and the need for more widespread Human Factors education.

The qualitative evidence provided by the telephone interviews demonstrated how the workshop enabled individuals to amend their own practice, and also educate colleagues. Numerous specific examples illustrated how attendees had improved patient safety by transferring their learning from the workshop into their individual or team's practices.

The lead consultant uses the key learning themes identified by the telephone interviews alongside attendees' written

feedback after each workshop to focus the teaching on areas attendees have identified as relevant and transferable to their healthcare practices.

5) Strategy for improvement: This qualitative study uses staff feedback as a proxy measure to demonstrate improved patient safety and outcomes when staff are educated about Human Factors and to understand how attendees incorporate this knowledge into their working environment and relationships with other staff.

The Human Factors workshops continue to be delivered to a regional multi-disciplinary audience on approximately a monthly basis. Written feedback continues to record attendees' learning points to ensure the content remains relevant and builds upon the findings of these interviews.

A voluntary session at the end of each workshop educates attendees on how to use their learning to teach their colleagues about Human Factors. These sessions allow attendees to incorporate the key learning points of others, as identified by the telephone interviews and written feedback, when delivering their own local Human Factors teaching.

6) Measurement of improvement: The interviews focused on attendees' key learning points from the one-day Human Factors workshop, and asked attendees for specific qualitative evidence if they felt they had transferred their learning into their clinical or non-clinical practice. These interviews were transcribed, coded and themed using framework analysis.

7) Impact: To the best of our knowledge this is the first qualitative study into the transferability of Human Factors education into individuals' healthcare practice. The themes identified by the interviews could be used as a basis to develop future Human Factors curricula.

8) Lessons learnt: Qualitative feedback at a later date to the written feedback on the day of the workshop can further illuminate attendees' learning and the impact of Human Factors education on patient safety. This can help focus the content of further workshops.

9) Message for others: Human Factors teaching can be successfully delivered to multi-disciplinary staff with qualitative evidence of improved patient safety. Workshops can develop local leaders in the field and help to disseminate this new concept to other healthcare staff. The Human Factors workshop powerpoint slides are available free-of-charge to all requesting NHS Trusts.

Taking the lead on PSHE – the spiritual, moral, social and cultural (SMSC) development of primary school-age children to tackle our crisis in mental health

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Kiran Raja Eyre*. Brighton and Sussex Medical School, Coombs Road Primary School

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Spiritual, Moral, Social and Cultural (SMSC) teaching provides a vital opportunity to educate young people about their mental health. Whilst OFSTED encourages a broad and balanced curriculum, there is little standardisation of Personal,

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

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

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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 subspecialty, 30 mins/week variation between subspecialties. 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.