(ACE). The knowledge gained from this pilot shows that it is feasible to recruit, train and utilise the unique skills of patients as volunteers to support other (newly diagnosed) patients to accept their chronic, life changing condition, make informed choices about their treatment while empowering them.

We have the proof of principle that PEs can meet the needs of renal units, working within the NHS Trust volunteer/governance framework. This initiative is low cost, demonstrating new ways of working and managing, empowering patients and utilizing non-clinical workforce through effective leadership.

104 IMPROVING HEALTH OUTCOMES BY A SOUTH LONDON LOOKED AFTER CHILDREN'S (LAC) TEAM

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Context There is an obligation on the local authority and its health partners to ensure these statutory health assessments take place in accordance with the timescales set. The looked after children's health team delivers this responsibility on behalf of the local authority. A significant portion live outside the borough boundaries. The multidisciplinary team comprises specialist nurses, community paediatricians and administrative team.

Issue Timely and thorough health assessments are vehicles for identifying and acting upon previously unmet health needs in this vulnerable population.

Assessment of issue and analysis of its causes The Change Management Framework

The ADKAR® model of change was utilised. The team were *aware* of the need for change. The trust executive and management had a *desire* to support and participate in the change. We utilised the *knowledge* of the core team and additional expertise. We have also established a system of *reinforcement* to sustain the change.

The strategy:

To deliver on the changes needed a clear leadership strategy was in place.

- It was *purpose driven*
 - Previous inspection reports, user feedback and performance indicators were used
- Clear and constant two-way *communication* was employed
 - weekly performance huddles, and
- *Investment* in people and infrastructure occurred
 - job plans developed, and increased training and development opportunities given
- We demonstrated *persistence* to see the changes through
 - Improvements were shared on the ground at team meetings, at directorate level; and at Trust executive level. The changes were shared with the Service Improvement Board, the CCG Safeguarding executive and the local authority.

Measurement of improvement and impact:

- In March 2018 100% of children accessing initial assessments were seen within 20 working days from referral; the graph (figure 1) shows the overall trend of improvement

Abstract 104 Figure 1% of children accessing initial assessments within 20 working days of referral- April 2017 to May 2018

- There is now knowledge of where all LAC are in the pathway, including those that are being seen out of borough and those that are in secure accommodation
- Improvement in staff morale measured by a fully established team, reduction in staff turnover rate and sickness levels

Impact The next steps are:

- Sustaining cultural and process changes in both the clinical and administrative team
- Continue to work with social care to improve the referral process
- Ensuring systematic oversight of the completion of health recommendations arising from assessment.

105 DOCTOR (NOUN, LATIN), TO TEACH; TRANSFORMING A WORKING WEEK INTO A TEACHING WEEK

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One of the prerequisites to successfully complete Core Medical Training in the UK is to acquire the MRCP title by passing the Practical Assessment of Clinical Examination Skills (PACES). Due to work pressures and time limitations, little teaching had been taking place locally at Eastbourne District General Hospital (EDGH). Prior to this, PACES teaching was mainly delivered externally by expensive courses, online resources and books. Given the plethora of patients in a familiar environment of an NHS hospital, we established that this provided an ideal combination for PACES teaching.

We started a team of PACES positive trainees who were interested in teaching; this team would deliver bedside PACES teaching at least twice a week. A weekly timetable with specified PACES teaching was created (e.g table 1). This included some specialised clinics that were consultant led (rheumatology and ophthalmology) aimed at providing consultant led teaching to PACES candidates. One PACES candidate was allocated on each clinic day providing 1-to-1 focused teaching, while the bedside sessions were open for everyone. A WhatsApp group was also created consisting of all candidates preparing for PACES and instructors, which encouraged all members to share interesting cases deemed good for PACES teaching and also facilitated organising unscheduled teaching.

The feedback from all candidates has been very positive so far (figures 1, 2, 3, and 4). We have improved confidence levels and most candidates are currently satisfied with the current PACES teaching structure at EDGH. In addition, most candidates found that supervised bedside practice is one of the top two useful methods to preparing for PACES. There is room for improvement taken from the feedback in that we could involve more senior members (consultants and registrars) in providing the bedside sessions and to have more stations 2 and 4 (history taking and communication skills) practice sessions.

106 MAINTAINING ESSENTIAL PHYSICAL HEALTH CHECKS IN AN ACUTE PSYCHIATRIC HOSPITAL

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10.1136/leader-2018-FMLM.104

Summary

- The RCPsych advises ECGs on newly admitted patients.
- ECGs were not performed within the recommended timeframe. This negatively impacted patient safety.
- Introduction of a three times weekly 'board round' check increased compliance with the standard.
- ECG machine availability is recognized as one factor in failing to adhere to the 48 h standard.

Background The RCPsych published integrated physical health guidelines for newly admitted inpatients, outlining the need to 'arrange physical health checks within 48 h' including ECGs to exclude cardiac side effects of psychotropic medication.¹

Method A baseline audit conducted in December 2016 showed that only a small proportion (33%) of patients had an ECG performed within 48 hours of admission. A 3× weekly 'Physical Health Board Round' was introduced on three wards to see if this improved compliance. A re-audit was undertaken in May 2017 to assess if there had been any improvement in the frequency of performance and documentation of ECGs.

Results After the intervention, ECGs were performed within 48 hours of admission in 45 cases and not in 68 cases. The most common reason an ECG was not performed was that the patient declined (n=23). The compliance therefore increased to 45/90=50%

Conclusion Implementing 3× weekly physical health 'board round' improves ECG compliance. 50% of patients are still not receiving ECGs, some with no explanation. Further work should be undertaken to explore this deficit. Investment has been made into further ECG machines for the hospital as a result of this study.

REFERENCE

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E-handover: Passing the electric baton to enhance communication

107 HANDOVER AND COMMUNICATION

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Introduction Handover is a dangerous time in a patient's journey. Sub-optimal communication can lead to confusion, ambiguity, delays in treatment, medication errors and foster a culture of a lack of accountability.

Aim An electronic handover system (e-handover) was developed with the aim of enhancing communication and improving patient safety through creating an electronic, auditable trail of all handover between doctors and nurses.

Method Following stakeholder engagement (including patients), bespoke e-handover software was designed "in-house" that intelligently links with other trust electronic databases used for documenting in patient notes, admitting, referring and discharging patients. Clinicians input patient tasks to be completed (via SBAR system or equivalent) into e-handover both in hours and out of hours. Handovers are triaged and delegated to appropriate "on call" clinicians who have been provided with tablets that can access e-handover remotely.

Implementation Following a successful pilot, it has rolled out to all 48 level one wards in the trust with over 1,000 staff members trained. It has since been expanded to include communication with pharmacists.

Results Compared with the previous system of handover, the quality of SBAR style handover has improved by over 60% and the percent of illegible handovers has fallen from 9.3% to 0%. The documented names of staff uploading and signing off tasks have increased from 33.5% and 32.1% respectively to 100%, and the documented time that jobs have been completed has improved from 0% to 89.4%. The volume of jobs on e-handover has also fallen by 42% compared with the previous "red book" system, allowing staff more time to focus on unwell patients and patient flow. 92% of staff (n=81) feel that e-handover is user friendly and 91% would recommend it. Importantly, 71% feel that handovers are safer and 61% feel that patient safety has improved as a result of e-handover. The mean number of cardiac arrests as calculated by t-test has also fallen since introduction of e-handover (p=0.032), although causality cannot be determined due to other electronic systems for sepsis and recording resuscitation status having also been introduced on a similar timescale.

Conclusion E-handover is a user friendly and effective method to improve the quality and accountability of handover, improving patient safety and is easily scalable throughout the whole NHS.