

since initial implementation, which is a difficulty of sustaining quality improvements over a large time scale. Ways to improve/sustain the improvement need to be explored, with suitable patients identified prior to the weekend effectively. The improvement shown in this study provides evidence for expansion of weekend discharge ward rounds to other trusts, enabling regions and the NHS as a whole to get well patients home, and provide improvements in bed flow and cost savings for the NHS.

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IMPROVING THE PARTICIPATION OF HEALTHCARE PROFESSIONALS IN CONTINUING MEDICAL EDUCATION ACTIVITIES (CMES) IN ANURADHAPURA DISTRICT IN NORTHCENTRAL PROVINCE – SRI LANKA

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10.1136/leader-2019-FMLM.60

Background Teaching Hospital Anuradhapura[THA] is the largest tertiary care hospital in Anuradhapura district(1100000 population, area 7179 km² with 82 health institutions). I held presidency of Anuradhapura Clinical Society(ACS),which is the leading clinical academic society in Northcentral Province and led the council(two secretaries, two treasurers and 46 council members) in 2018/2019. Main objective of ACS is to organise CMEs for healthcare professionals in the district(92 specialists & 357 doctors). Poor participation was evident especially from peripheries. Lack of awareness about CMEs, logistical difficulties to travel, difficulties in getting time-off were identifiable causes.

Aims Improve participation of healthcare professionals of the Province in CMEs at THA.

Methods Repeated discussions with the council members, administrators and medical officers covering all institutions were used to get ideas and feedback. Multiple interventions were implemented such as, innovative methods to increase awareness of CMEs(internet based social media, posting information flyers, phone reminders), supporting to get time-off, pre-arranged transportation for peripheral doctors, engaging target group in organising(giving ownership) and methods to attract participants. Involvement of eminent speakers, use of accessible and attractive external venues, organising events for other staff were done.

Results Number of CMEs organised increased from 18 to 29 (2018/19). Mean number of participants for an event increased from 62 to 91. Participation of doctors from peripheries and THA increased. Participation of peripheral doctors increased by 19.2 fold compared to 2017/18.378 other health professionals participated (54.7% from peripheries).

Conclusions In comparison to 2017/18, participation and enthusiasm among health professionals about CMEs increased. Perseverance and innovation with maximum membership involvement, teamwork and multisectoral collaboration contributed to success.

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IMPROVING THE RELIABILITY OF PHYSICAL OBSERVATIONS MONITORING ON AN INPATIENT PSYCHIATRIC WARD

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10.1136/leader-2019-FMLM.61

Mersey Care NHS Foundation Trust Policy states that as a minimum, all psychiatry inpatients should have their physical observations 'undertaken and documented weekly'. Consensus amongst staff at Rathbone Rehabilitation Centre, a 26-bed psychiatric rehabilitation facility, was that compliance was sub-optimal. Staff were concerned that failing to monitor the vital signs of our patients would reduce the early detection of illness in our particularly vulnerable patient group.

In the 6-week pre-intervention period, the percentage of patients having their observations measured each week ranged from 29% to 71%, with a median of 52%. Conversations across the MDT exposed three significant barriers to compliance:

1. Staff knowledge and education
2. Workforce weekly schedules
3. Method of recording observations

I implemented a series of interventions to overcome the above barriers:

1. I held conversations with all staff involved with undertaking observations to ensure that they were aware of both the guidelines, and the positive impact that adherence has upon patient care.
2. I therefore worked alongside the Ward Manager to ensure that protected time for staff to complete observations was introduced to the weekly timetable.
3. I introduced simple tick-box sheet at the front of the observation folder so that at a glance, staff could see which observations were still outstanding.

After implementation, we experienced a significant improvement over the following 6 weeks. The percentage of patients having their observations undertaken in any given week ranged from 72% to 100%, with a new median of 90%. Run chart analysis demonstrated a shift, as all 6 post-intervention data points were situated above the initial median of 52%, thereby demonstrating a statistically significant improvement.

This project demonstrated how a series of simple interventions led to a statistically significant increase in our adherence to Trust Policy, and a subsequent improvement in patient care.

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INNOVATING AND IMPROVING THE TEACHING PROGRAMME FOR MEDICAL STUDENTS AT ROYAL SURREY COUNTY HOSPITAL

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10.1136/leader-2019-FMLM.62

Introduction The transition from medical school to the NHS Foundation programme can be challenging. This project aimed to use these standards to improve the service provision and quality of medical student teaching at RSCH to develop a teaching programme tailored to support final year medical students as they prepare to become the new generation of Doctors.

Methods There were four elements of the teaching program:

1. Mock OSCE: Practical assessment of clinical skills with individualised feedback.

2. Bedside teaching: FY1 led teaching on inpatients at RSCH.
3. Lecture based teaching: Weekly lectures delivered by FY1's covering all aspects of the medical curriculum.
4. Mentorship programme: Final year students assigned to FY1's for career advice.

Results Mock OSCEs

100% of students found it useful and well organised. Recruitment of real patients was largely unsuccessful thus necessitating the use of professional actors.

Bedside teaching

100% of FY1's enjoyed this form of teaching and felt a list of students was provided in a timely manner. The teaching was not timetabled, and it was noted there was difficulty in arranging the teaching. 85% of FY1's felt this was due to conflicting schedules.

Lecture based teaching

100% of participants enjoyed this form of teaching. Importantly a senior doctor observed none of the lectures. FY1's received feedback directly from medical students.

Mentorship program This program was unsuccessful due to 1) limited FY1 and medical student time 2) unclear distinction between bedside teaching and mentoring program.

Conclusion

1. Both FY1's and students benefit from medical education
2. Observation of lecture-based teaching from a senior doctor with constructive feedback is needed
3. Mock OSCE could be expanded to cover more topics.
4. Consultant-led patient recruitment will improve Mock OSCE
5. Mentoring and bedside teaching should be combined with clinical and social support provided by the same F1

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INTRODUCING PHYSICAL HEALTH CLINICS TO INPATIENT PSYCHIATRIC WARDS

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10.1136/leader-2019-FMLM.63

Patients with a severe mental illness (SMI) experience significant physical health inequality compared to the general population, resulting in a 15–20 year reduction in life expectancy. Estimates suggest that 60% of the excess mortality in patients with SMI is avoidable, demonstrating the necessity for healthcare professionals to take action. The aim of our project was to determine whether introducing a 'Physical Health Clinic' on an inpatient psychiatric ward led to improved management of physical health for these patients.

Using the criteria and standards as set by the Academy of Medical Royal Colleges to assess the physical health in SMI patients, retrospective analysis of 17 inpatients on a psychiatric working-age male ward was conducted. A 'Physical Health Pro-Forma' was designed and integrated within a weekly 'Physical Health Clinic', and re-audit data was compared against baseline data to assess the impact of the clinic.

Introduction of a 'Physical Health Clinic' demonstrated a marked improvement to all physical health parameters, in particular cardiovascular risk, infectious disease risk and oral health monitoring. Baseline compliance identified that

only 12% of inpatients had a subsequent physical health assessment following admission, compared to 100% of patients after clinic introduction. Increased focus on physical health led to several new diagnosis of illness and conditions, including diabetes, spinal fractures and serious infectious diseases.

Initial compliance with physical health standards was poor. Introduction of a weekly clinic significantly improved physical health compliance, demonstrating an improvement in physical health management. Following discussion with Trust Medical Directors, the clinic is being implemented Trust-wide to all inpatient psychiatric wards, thereby enabling greater data collection and research into the physical health of these patients with overall aims to improve health management to psychiatric patients.

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JUNIOR DOCTOR SERVICE IMPROVEMENT BOARD; AN INCH WIDE MILE DEEP APPROACH TO TACKLING THE BARRIERS FOR CHANGE

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10.1136/leader-2019-FMLM.64

Background In 2013 the Junior Doctor Service Improvement Board (JDSIB) was created to support multi-disciplinary staff in Quality Improvement Projects (QIP) across Dartford and Gravesham NHS Trust. In 2018–2019 the JDSIB introduced four co-chair roles from varying specialities. This unique advantage provides valuable perspectives and crucial trust-wide links.

Aims Identifying and supporting opportunities for meaningful, sustainable improvement.

Methods JDSIB's rebranding using distinct logos and colour scheme improved visibility and recognisability and thus engagement. Despite staff identifying areas for improvement across the Trust, there was a perceived notion that the culture was not receptive to change. To tackle this, JDSIB held regular events to showcase QIP ideas in the presence of senior key leaders such as the medical director, CEO, and the audit team. These forums discussed solutions to roadblocks and provided a dedicated space to listen to, and inspire new projects. Cross-team collaboration with the audit team proved crucial in combining resources, expertise and preventing duplicated effort.

Results JDSIB was deemed 'inspirational' by management and 'very useful' by colleagues. JDSIB linked motivated individuals and supported colleagues in implementing QIPs, but most importantly emphasised that investigating roadblocks can lead to sustainable solutions. Challenges ranged from co-ordinating rota commitments with events, to influencing senior staff involvement.

Conclusion Employing a senior solely dedicated to QI and leadership would be a useful resource. The strong emphasis on junior doctors to become more engaged, provides opportunities for organisations to nurture their trainees for future leadership roles. Trust wide engagement is by no means an easy feat, yet slowly changing micro-cultures is the start to embracing wider change. The JDSIB are dedicated to encourage improvement and support healthcare professionals to create meaningful change.