and established a clinical network. This provides a strong basis on which the commissioning team can take forward an option appraisal process.

110 THE TRIGGER PROJECT: INTRODUCING ELECTRONIC PATIENT REPORTED OUTCOME MEASURES INTO RADIOTHERAPY SERVICES

[1]A Macnair*, [1]A Sharkey, [2,3]K Le Calvez, [4]R Walters, [5]L Smith, [6]A Nelson, [7,8]J Staffurth, [3,9]M Williams, [10]D Bloomfield, [11]J Maher, Trigger Project Collaborative group. *[1]Macmillan Cancer Support and Royal College of Radiologists, Royal college of Radiologists, London; [2]Charing Cross Hospital, Radiotherapy Department, London; [3]Computational Oncology Laboratory, Institute of Global Health Innovation, Faculty Building, South Kensington Campus, Imperial College, London; [4]Pelvic Radiation Disease Association, Epsom; [5]NHS England National Cancer Programme, London; [6]Marie Curie Research Centre, Division of Population Medicine, School of Medicine, Cardiff University, Cardiff; [7]Velindre University NHS Trust, Cardiff; [8]School of Medicine, Cardiff University, Cardiff; [9]Charing Cross Hospital, Radiotherapy Department, London; [10]Brighton and Sussex University Hospitals NHS Trust, Brighton; [11]Macmillan Cancer Support, London*

10.1136/leader-2019-FMLM.110

Patients receiving pelvic radiotherapy can experience long term GI side effects post-radiotherapy. The Trigger project identifies patients experiencing symptoms of radiation-related bowel toxicity using the ALERT-B questionnaire, and directs them to the appropriate clinician. Trigger is a service evaluation project, aiming to prove the utility of electronic PROMs, and to demonstrate the feasibility of a low-resource project as a model for collecting PROMs. It is a collaboration between Macmillan Cancer Support, the Royal College of Radiologists, and three NHS Trusts: Velindre, Imperial College Healthcare and Brighton and Sussex University Hospitals.

Patients register on the Trigger website, hosted by My Clinical Outcomes, and receive periodic emails to complete the short ALERT-B questionnaire electronically, to screen for long-term bowel symptoms which could have been caused by pelvic radiotherapy. If answering 'yes' to any of the questions, patients are directed to appropriate services. 6 months following the completion of their radiotherapy, patients are sent a separate questionnaire to evaluate the utility of the project.

336 patients registered in first the 9 months across the 3 sites. Patients with a range of different cancers signed up: anal (2%), bladder (1%), prostate (87%), rectal (4%) and gynaecological (6%). 43 patients (/65 (uptake 66%)) have answered their 6-month post treatment questionnaire, and 72% answered 'yes' to at least one of the ALERT-B questions. 85% of responding patients reported they found the Trigger project helpful.

These promising results show that electronic PROMS can be introduced in radiotherapy departments using a low resource model. The Trigger project works as a feasibility model, showing patients engage with electronic PROMs projects, and find them useful. PROMs for other tumour types could be collected in a similar manner, based on the low-resource model used here, using site-specific PROMs based on the ALERT-B tool.

111 MEDISENSE TECHNOLOGY FOR BREAST CANCER

Aswini Misro, Vikash Sharma. *Kings College NHS London, UK and University of Hull, UK*

10.1136/leader-2019-FMLM.111

Introduction It is not uncommon for a patient coming to the NHS to present with investigations and treatments done in EU countries and outside the EU for various medical and surgical conditions. Many times, reports are written in languages other than English and therefore does not to contribute to medical consultations.

Another issue with the patients is that they feel helpless and frustrated when they can't understand what the reports mean for them. To resolve these problems, we developed a technology called Medisense is a medical report image capture, data extraction, validation and interpretation technology. By using this technology, doctors and patients can take a snap of the picture of any report and get an instant translation, interpretation and review of the report.

Study design In the current study, we carried out 97 cases of breast cancer histopathology reports of various patients. The test was carried out using a specified protocol in a test environment.

Results The study results show that in all the 97 cases, the image capture was successful. However, the data extraction was successful only in 93 cases. In 90 cases, the data interpretation was correct. In the 4 instances where image capture was not successful, the poor printing quality of the report (n=1), folds and creases in the report(n=1), and technical error(n=2) was responsible.

Conclusions Medisense will be a helpful tool in medical consultations when a patient arrives with a report in a non-native language. This would also help patients interview and interpretation of their medical reports. Further studies and improvements are required to optimise this technology further.

112 NEW RAPID ACCESS UROLOGY CLINIC

[1]Emily Simon Thomas, [2]Rachel Hawthorne, [3]Ayah Babiker, [2]Kai Chi Chan. *[1]Oxford Health NHS Foundation Trust; [2]Oxford University Hospitals NHS Foundation Trust; [3]Buckinghamshire Health NHS Foundation Trust*

10.1136/leader-2019-FMLM.112

Rapid access urology clinics had been trialled elsewhere in the country with variable success. ED, urology consultants and registrars, and senior nurses (i.e. the stakeholders who would be directly impacted by this intervention) were involved in the decision to convert two side rooms to such a clinic in our DGH. The aim was to see non-elective urology patients efficiently to ensure prompt management and avoid admission where possible.

The proposal and initial data were discussed in the monthly urology governance meetings. The pilot started in August 2018. Patients could be referred by ED, GP, other hospital departments via the on call urology registrar or self-refer. Patients discharged from the urology ward were informed about this, as were ED staff, GPs, and other departments such as radiology and oncology. Feedback from patients and ED staff were welcomed and outcomes measured.

Data was collected prospectively during an initial 47-day pilot period and the subsequent three months. Each attendance was reviewed individually. The hot clinic saw 107 patients in the pilot period and 217 in the subsequent three months. ED avoidance was estimated at 61% in the trial

period and 43% in the subsequent period. Length of stay prior to hot clinic was 3.63 days, 2.57 days in the pilot period and then went down further to 1.7 days – to 53% of baseline. Admission avoidance was 41% in pilot and 32% subsequently.

The Urology Hot Clinic has had a significant impact on reducing ED attendance and length of stay of urology patients in our hospital, and on admission avoidance. It has streamlined the patient pathway reducing burden on multiple departments and patients. The success of the hot clinic at our hospital could serve as an example for other urology departments and potentially other specialties.

113 IMPROVEMENTS IN SEPSIS CARE

Nicola Penrose, Sally Knightly. *Royal Oldham Hospital, UK*

10.1136/leader-2019-FMLM.113

The Royal Oldham Hospital is an acute site with a Cat 1 Emergency Department serving a population of 235,000. In 2018–19 there were 110,000 ED attendances with 30,000 emergency admissions.

With over 1500 patients admitted each year with sepsis and around 1 in 5 (20%) dying in hospital sepsis is a high volume, high mortality and high impact condition.

A multi-disciplinary sepsis steering group was set up chaired by a sepsis lead clinician with input from key clinical areas along with quality improvement team. Worked with Advancing Quality Alliance using a sepsis measure set to track care.

Strong, enthusiastic, leadership backed by senior support and evidence based quality improvement methodology allowed us to embed a number of changes. Involvement of all staff groups and specialities has led to a change in culture where staff now consider sepsis early in a patients journey and know how to escalate and treat sepsis.

- Sepsis champions
- Sepsis intranet page, e–learning and face to face education packages
- Changes to IT system to ask about sepsis at triage and if patients score on NEWS2
- Fortnightly sepsis microsystem meetings
- Sepsis lead visible and accessible for direct feedback
- Key ED staff identified to encourage use of sepsis screening tool at triage
- Tests of change introducing new ways of working when successful such as escalation stamps

Sepsis data was collected throughout the year for the AQuA measure set and national CQUIN.

Target for AQuA was 75% of measures achieved and this was met. 2018/19 CQUIN data showed improvement for patients receiving antibiotics within an hour from 70% in Q1 to 86% in Q4 in ED and from 75% in Q1 to 91% in Q4 for inpatients.

Cultural change within TROH backed by specific system changes with senior support means that patients at risk of sepsis are identified, assessed and treated in a timely manner. Empowering staff to identify risk of sepsis and appropriately escalate and treat means both patients and staff benefit.

114 LEADING A QUALITY IMPROVEMENT PROJECT ACROSS A LONDON-BASED SEXUAL HEALTH SERVICE

[1]Vardah Alam, [1]Lucia Yin, [1]Hadiya Khan, [1]Laura Tincknell, [2]Emma Wallis, [2]Gulshan Sethi. *[1]GKT School of Medical Education, King's College London, UK; [2]Guy's and St Thomas' NHS Foundation Trust, UK*

10.1136/leader-2019-FMLM.114

Background Recent BASHH Guidelines recommend testing for Mycoplasma genitalium (MG) in clinically indicated conditions (CIC); non-gonococcal urethritis (NGU); epididymo-orchitis; pelvic inflammatory disease (PID). The aim of this quality improvement project was to ensure that 100% of clinically indicated patients were tested for MG across the Guy's and St Thomas' trust Sexual Health service.

Method Baseline data was collected over five weeks and it was identified that the median number of clinically indicated MG tests carried out were as follows: 60% for NGU, 63% for PID and 100% for epididymo-orchitis. Subsequently, three Plan-Do-Study-Act (PDSA) cycles were planned:

- Ensuring that all staff had IT access to the order set for MG by liaising with the relevant staff
- Holding a departmental educational event about testing for MG in conjunction with displaying posters clinical areas
- Sending reminder emails to clinicians who didn't test clinically indicated patients for MG.

A sample of 10 patients for each CIC per week were analysed to identify the percentage tested for MG; results were plotted on run charts.

Results There was a sustained increase in the number of NGU cases appropriately tested for MG following the cycles. No increase in MG testing was seen in PID and epididymo-orchitis, however, the median number of patients each week was low (7.8 and 2.3 respectively). The rate of inappropriate testing for MG was also analysed and found to be high at 15%.

Discussion We have demonstrated sustained improvement in MG testing in NGU patients but not for the other CICs; the significant number of inappropriate tests performed warrants further work. Key staff members were involved in the planning stages of the project and therefore, were made aware of the changes through meetings, emails and the teaching event held. This optimised staff involvement and meant that we were able to gain feedback.

Understanding Leadership Through Research

115 THE UMBRELLA EXPERIENCE REDESIGNING CONTRACEPTIVE SERVICES IN A TIME OF AUSTERITY

Rhiannon Murphy. *University of Birmingham*

10.1136/leader-2019-FMLM.115

Background Following the 2012 Health and Social Care Act, Local Authorities became responsible for the provision of Sexual and Reproductive Health services. Birmingham City Council and Solihull Metropolitan Borough Council redesigned their service and introduced an integrated, lead provider model through Umbrella Health.