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76 STAFF RE-ALLOCATION DURING THE COVID-19 PANDEMIC: IMPROVING THE JOB ROLE CONFIDENCE OF MEDICAL SHOS THROUGH THE DEVELOPMENT OF A DIGITAL HANDBOOK

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Introduction During the spring of 2020, medical training for junior doctors was largely suspended to prepare for the evolving Covid-19 pandemic. During this time junior doctors were reallocated to other departments, many of whom began working as part medical teams. As a result, many doctors needed to relearn the protocols and the conventions of their new role. This quality improvement project aims to review how prepared junior doctors reallocated to medicine felt at the start of the Covid-19 pandemic and whether this was improved through the development of an on-call handbook.

Results An initial survey of junior doctors (n=19) asked where they had gained information about their job roles and whether they would find a handbook of information useful; 82% felt a handbook would be of use. The majority of doctors (95%) were receiving information about shifts through unofficial channels such as word of mouth and messaging groups. The 'Medical SHO On-call Handbook' was developed by the authors. Junior doctors (n=9) were then asked in a repeat questionnaire about their shift confidence following the release of the handbook and whether they found it a useful resource. For all available job roles, shift confidence increased (mean +24%) and overall lack of confidence reduced (mean -8%). 78% of doctors found the handbook useful.

Key Features of the on-call handbook:

- Information for all the on-call shifts with the specific role and top tips.
- IT information is specific to the local electronic patient records system.
- Hospital maps and information about rest areas.
- Official information from medical on-call administrators regarding annual leave.

Recommendations and actions

- Release the on-call handbook to all medical SHOs via an email and intranet access.
- Organisation of a handbook committee to review the handbook in next year and develop a second volume.

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77 IMPROVING THE INITIAL INPATIENT BLOOD INVESTIGATION OF COVID-19 PATIENTS AT THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST: A QUALITY IMPROVEMENT PROJECT

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Background The COVID-19 pandemic highlighted the importance of evidence based guidelines and many studies have been published to identify appropriate investigations that may be used as predictors of mortality and ITU admission. The Hillingdon Hospitals NHS Foundation Trust (THH) produced trust guidelines for the initial blood investigation of COVID-19 inpatients. However, lack of awareness and education on these guidelines meant adherence could be improved.

Aims To improve adherence to the local trust guidelines, targeting clinicians involved in the initial assessment of patients presenting with COVID-19 symptoms where appropriate.

Methods Between 16th April 2020 and 14th April 2020, investigations performed for positive COVID-19 cases were compared to guidelines. Results were presented locally and a COVID-19 panel was added to the electronic order-request system that allowed prompts for appropriate investigations. A re-audit between 15th May 2020 and 14th June 2020 was conducted to assess adherence post-intervention.

Results 383 patients were identified in the initial audit cohort, and 20 patients were identified in the re-audit cohort. Adherence to Full Blood Count, Urea and Electrolytes, C-Reactive Protein and Liver Function Tests increased to 100% (from 99.7%, 99.2%, 98.7%, and 96.6% respectively). Coagulation screen adherence increased from 72.8% to 90%. D-dimers were appropriately requested more often, increasing from 19.9% to 50%. Inappropriate troponin requisition decreased from 38.9% to 26.3%.

Conclusions Reduced COVID-19 admissions meant that the re-audit cohort was not as large as the initial audit cohort. However, a user-friendly COVID-19 panel of investigations resulted in better-targeted management of patients, and improved adherence to guidelines. This showed the importance of disseminating information effectively. Education is essential during times of uncertainty, especially during a pandemic.

Psychiatric emergency plans

78 IMPROVING PSYCHIATRIC EMERGENCY PLANS IN SCOTLAND

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Aim To create a template Psychiatric Emergency Plan (PEP) for use by Scottish Health Boards when reviewing their PEPs.

Background PEPs are reviewed by health boards on a regular basis and at least every five years. PEPs are recommended by the Mental Health (Care and Treatment) (Scotland) Act 2003 Code of Practice as a means to help manage the detention of a patient and aspects of multi-agency working. They are also recommended by the Police Scotland Standard Operating Procedure in dealing with patients who present in mental health crisis.

Methods We incorporated the view of patients and carers, Police Scotland, Scottish Ambulance Service, Emergency Departments, and from our own team with practitioners with a background in General Adult Psychiatry and Social Work in

creating the template. We reviewed PEPs from each Scottish Health Board using our template to establish whether the template could be used to help improve quality of PEPs in Scotland.

Outcomes From our consultation process, we found 14 broad themes which we felt were a priority to consider within a PEP: Initial contact; Place of Safety; Alcohol and Substance Misuse; Transport; Resolving Disputes; Assessment; Sharing Information; Missing Patients; Young People; Carers and Patients with Caring Responsibilities; Homelessness; Learning Disability and Autism; Aftercare; Use and Relevance of PEP. In total our template consisted of 63 requirements. We found that there was no heading which had not been addressed by any health board but that many requirements had not been met by all health boards.

Conclusions We have designed a template which addresses broad themes considered in most health boards already. However, not all our requirements were met by every health board. Our template could be used to raised the standard of Psychiatric Emergency Plans and therefore raise the standard of care and patient experience in Scottish Health Boards.

Exception reporting

79 A QUALITATIVE STUDY ON EXCEPTION REPORTING IN YORKSHIRE

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This piece of qualitative research looks into the attitudes of managers, consultants and junior doctors towards the exception reporting process that was introduced as part of the new junior doctors' contract in December 2016.

The qualitative interviews, conducted in both structured and semi-structured format, provide a range of themes that lead to numerous recommendations for consideration by central government and lobbyists such as the British Medical Association (BMA) as to how the process could be improved.

The major themes that were identified by the interviews are; apathy, cultural issues, safety, stigma, junior-led process, training and practical issues. These are explored in some detail in the paper, with direct quotes evidencing each provided, together with a commentary.

The main recommendations include; an England-wide campaign on exception reporting to address cultural issues and stigma, more active involvement of consultants in the process, treating exception reports as a 'near miss' event from a safety perspective, lengthening timelines and introducing penalties for breaching such timelines, allowing for doctors to claim for training opportunities and address practical issues around reporting such as provision of a username and password that is the same as other IT systems in the Trusts.

Further areas of research recommended is an England-wide survey based on the themes that were elicited by the interviews, as well as the facility for further free-text comments from individuals in a survey format in order to collect

quantitative data and confirm the themes with further qualitative input.

Education of antimicrobial stewardship: teaching methods and their effectiveness

80 EDUCATION OF ANTIMICROBIAL STEWARDSHIP: TEACHING METHODS AND THEIR EFFECTIVENESS

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Each year thousands of lives are lost due to antibiotic-resistant infections. In order to combat the alarming rise in antibiotic resistance in the UK, guidance has been published by organisations such as the World Health Organisation and the National Institute for Clinical Excellence to help govern the use of antibiotics. In 2018 our team conducted an audit investigating antimicrobial stewardship on the general surgical wards at the Queen Alexandra Hospital, Portsmouth. This demonstrated poor compliance to the national guidance in the UK on safe antimicrobial prescribing. Our initial intervention was creating posters on the correct procedure of prescribing antibiotics in key clinical areas to promote good practice. A re-audit showed a minor improvement in compliance however this was not significant and consequently we looked into different ways of changing clinical practice. We chose to explore whether educating the prescribers about the importance of antibiotic stewardship and the clinical significance of that would be a more effective method of changing practice.

Working with the microbiology department, we formulated a teaching programme spanning four weeks. After the sessions were completed, we re-audited the surgical wards. This showed a clear improvement in compliance. This suggests the intervention was effective at impacting local clinical practice. We concluded therefore that it is possible and effective to provide relatively short and basic teaching schemes to effectively promote antimicrobial stewardship and change practice.

Leadership development

81 AN EVALUATION OF THE CLINICAL LEADERSHIP MENTORS PROGRAMME IN THE SOUTH WEST

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Aims There is an increasing evidence-base which suggests that the involvement of junior doctors in NHS leadership activities will improve services and enhance patient safety. In 2018, the HEE-South West Deanery established a Clinical Leadership