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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10.1136/leader-2020-FMLM.79

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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10.1136/leader-2020-FMLM.81

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

Mentor (CLM) programme, with mentors appointed in all of the 19 Trusts in the region. This initiative was designed to improve leadership development, with the CLMs creating opportunities for medical trainees in their Trust.

The NHS Leadership Academy commissioned a formative evaluation of the scheme to assess evidence for continuation and development of the role.

Methods The evaluation involved surveys of Trainee Medical Staff (n=112) and Educational Supervisors (n= 170) across 8 Trusts – 4 Mental health and 4 Acute Trusts. A total of 43 interviews with CLMs, Educational Supervisors, Trainee Medical Staff, and Trust Managers were undertaken with later thematic analysis of these interviews. Reports were also provided by CLMs themselves to Health Education England South West.

Results

Trainees 94% considered leadership an important part of their practice and the number who considered themselves a leader increased as seniority increased - with the transition to registrar being particularly significant.

Educational supervisors (ESs) 98% ESs thought leadership was an important element of medical training but only 82% discussed this with trainees and only 53% felt they understood the opportunities which are available for trainees. ESs were asked what specific CLM roles would be useful. All suggestions e.g. identifying leadership roles/projects and setting up systems where trainees can shadow leaders or managers, had 'approval ratings' above 90%.

Conclusions There is evidence to support the continuation and development of the role, with support from trainees, ESs, and Trust managers. Roles should be less specified, with more freedom for local development. The CLM group has been highly valued, although the time commitment is high.

Leading innovation and improvement

82 HARNESSING COVID-19 LOCKDOWN TRAINEE LEADERSHIP TO EXPAND A LOCAL HEALTHCARE WORKFORCE WELLBEING INITIATIVE NATIONALLY

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10.1136/leader-2020-FMLM.82

There is lack of access at work to free sanitary products, personal hygiene products and sleep aids for healthcare workers, especially after hours or if unexpectedly resting on site. This may adversely affect personal dignity, hygiene and ability to sleep comfortably, negatively impacting staff engagement, sense of being valued and belonging and workplace performance. More intense shift working and increased fatigue and need to clean after wearing PPE during the Covid-19 pandemic increased these challenges.

The Sanitary Products On Site (SOS) and Too Tired To Travel Home (T4H) boxes were established to meet these needs. Led by a junior doctor, they were piloted at three South East Wales acute hospitals, targeting junior and SAS doctors. All female doctor survey respondents felt that the pilot SOS box: was very useful; relieved concerns about being at work without sanitary products; and improves dignity, wellbeing and peace of mind at work. SOS box usage across a health board cost £0.33/week. T4H pilot survey respondents stated that personal hygiene products maintain dignity and wellbeing and improve their sense of being valued.

Expansion of the SOS and T4H box schemes in March-April 2020 in response to COVID-19 targeted all healthcare staff in Emergency Departments and/or Intensive Care Units at all acute hospitals and the new field hospital in Wales. Expansion involved recruiting individuals to site boxes in hospitals, fundraising and seeking box contents donations. Interim feedback was via user emails and social media.

The wellbeing box scheme expansion demonstrates that leadership can be flexible and delivered effectively via remote means. This involved expanding the Wales project, alongside empowering others to take a vision for positive change forward UK-wide. Leadership during a pandemic can be particularly powerful when meeting needs or channelling feelings of helplessness into purpose. Times of crisis provide momentum for positive change.

VTE risk assessment compliance

83 ASSESS THE RATE OF VTE ASSESSMENTS IN THE EMERGENCY DECISIONS UNIT (EDU) COMPLETED IN LINE WITH NICE GUIDANCE & TRUST POLICY

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10.1136/leader-2020-FMLM.83

Aims To understand the expected standard of care as outlined in NICE guideline 89 on reducing the risk of hospital-acquired venous thromboembolic events (VTE).

To identify the rate of completed VTE assessments and if indicated appropriate treatment was prescribed to ensure patient safety.

To identify areas of improvement within the department in order achieve a higher standard of compliance.

Methods Excel used to record information of patients discharged from EDU between 14/1/20 and 29/1/20. Data was analysed retrospectively to look at: presenting complaint, length of stay, indication for VTE prophylaxis and whether this was acted upon. Changes implemented focused on awareness, leadership and managerial issues identified. This led to the role of 'VTE champion' being created together with poster and flashcard reminders. Re-audit data collected between 10/2/20 and 23/2/20.

Results 278 patient data records in the preliminary data set

VTE assessment documented in 26.3%

210 patient data records in the post-intervention data set

VTE assessment documented in 41.4%

66.9% of patients had a completed VTE assessment in those where prophylaxis was indicated (63.3% pre-intervention)

87.1% of patients staying longer than 24 hours had a VTE assessment completed (63.7% preintervention)

Conclusion Overall there has been an upward trend in the number of assessments completed. EDU is a short stay unit where patients are typically discharged with 24 hours. Elements of the pre-admission checklist, such as the VTE assessment, are therefore easily overlooked. Our focus for implementing change been on improving staff awareness, and this has been partly achieved by the VTE champion initiative. This role underpins the core foundations of any leader: