spanning Croydon Health Services NHS Trust, CCG, Local authority, Primary care and the Voluntary sector. We present initial phase 1 reflections.

Interventions *Training: A tiered approach, equipping individuals with a calibrated skillset in QI methodology, providing mentorship & leadership.

*Communication: Establishing a designated CQI team & social media presence, developing a strong 'CQI' brand.

*CQI Hub: A physical space enables staff engagement and provides a 'visible' reminder of CQI.

*Integration: The CQI Board was created to ensure that all stakeholders were engaged and adopt one methodology across Croydon systems.

Measurement of improvement: Utilising the IHI 'Improvement Capability self-assessment' tool, generated benchmark results. These show a predominance for 'just beginning', 'developing' or 'making progress' with greatest developments seen in 'Improvement of Knowledge and Competence', 36.11% selecting 'making progress'.

Additionally, a CQI repository with over 100 QIPs enables analysis of trends. Projects are allocated domains for levels of complexity and note their level of engagement; 45% team-based, 47% single organisation and 8% multi-organisational.

Impact The start of a 'process' of change with CQI has been shown, however we must reflect on the challenges below;

*Capacity and focus : With multiple demanding pressures.

*Initiative fatigue: Risk of repetitive 'initiative' roll outs.

*Integration: Importance of building further stakeholders' engagement across systems.

*Training: Challenge of time and enthusiasm.

*Leadership and ownership: To drive and sustain the collective vision of CQI.

Reflections CQI is uniquely Croydon, by celebrating the opportunities towards collaborative working with our shared focus, we shall sharpen our alignment as we strive towards CQI being harnessed within our everyday practices.

Healthcare planning and strategies

204 BRIDGING THE PLANNING EXECUTION GAP: RCHSPY EXPERIENCE

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10.1136/leader-2020-FMLM.204

Planning execution gap is one of the main challenges facing strategists and planners because of its association with several factors. The study aims to explore the problem among all levels of the organization identifying its main impacts and root causes through combined approaches. The main results refer to the 4 'Cs' including effective communication, inter-departmental collaboration, overcoming financial and administrative constraints, and connecting strategies to daily operations as an effective and comprehensive approach to bridge the gap.

Leading innovation and improvement

205 TURNING A CRISIS INTO AN OPPORTUNITY FOR GENERAL PRACTICE TEAMS IN NI

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10.1136/leader-2020-FMLM.205

The emergence of COVID-19 saw a seismic change in General Practice with significant clinical, operational & educational challenges across the whole of the primary care team. Information & guidance from multiple different sources emerged at an overwhelming pace for practitioners. There was no robust way of cascading critical information to individuals. Shielded, remote & sessional health care professionals in particular lacked access to sensitive Health & Social Care Board information.

It was evident that there was a need for a centralised information platform for professionals. This would provide easily accessible, accurate & up to date information on service changes, operational & clinical guidance as well as legislative changes.

An MDT working group, with representatives from all professions including trainees was formed to design a central knowledge repository for the whole primary care team. This ensured all practitioners had access to the latest information, equipping them to deliver high quality care during the pandemic.

From concept to website launch took just three weeks, with a live web-based educational programme starting just one week later & acting as a catalyst for enhanced primary & secondary care understanding & communication.

There are over 150 attendees at weekly live ZOOM educational events, with the programme reflecting learning needs across the whole primary care team. Website analytics confirm 'Pageviews' >100,000 & 'users' >7,500 & rising with a global audience.

A crisis can bring exciting opportunities & a highly effective team can be created from conception in less than 4 weeks with a shared vision, enthusiasm & determination to make it work.

Collaborative learning between GPs, fledgling MDTs, & across the primary-secondary care interface has united colleagues around a shared purpose, starting solution-focused conversations. Working regionally has provided a platform for shared learning & standardised approach to high quality safe patient care.

Developing effective leaders

206 GET IT RIGHT THE FIRST TIME: REDUCING MEDICATION ERRORS IN NEUROSURGERY

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10.1136/leader-2020-FMLM.206

Introduction Errors in neurosurgery have been studied relating to surgical technique, equipment failure, anaesthesia and

nursing. To date, there are no studies identifying medication error rates. Patient safety is paramount and an essential component within neurosurgery, however, the complexity of processes and surgical conditions dealt with alongside intense pharmacological management pre-disposes patients to medication harm and suboptimal medication therapy. This is amplified by limited resources making it challenging for different professions to participate in collaborative meetings with support and expertise not being fully utilised and as a result increased medication errors.

Aim Quantify medication errors within neurosurgical-ICU

Methods Data from 99 patients was collected over 36 days during consultant-led ward rounds. Interventions gathered via electronic prescriptions and analysed on excel.

Results

- Addition of new treatment: 128 prescriptions
- Administration optimisation: 81 prescriptions
- Dose adjustment: 128 prescriptions
- Drug discontinuation: 1 prescription
- Drug monitoring: 21 prescriptions
- Drug switch: 61 prescriptions

Four medication errors per patient, prevented by specialist pharmacists working collaboratively in ward rounds.

Conclusion Medication errors are an understudied component of patient management in neurosurgery and are inevitable in human-driven systems. Prescribing errors are known to account for a substantial proportion of all medication errors and are an important cause of harm to patients. Multi-disciplinary ward rounds with the involvement of pharmacists should be a priority as a patient safety initiative. This intervention addresses both environmental and individual factors.

Ward rounds are an excellent opportunity to develop the core domains of leadership for junior colleagues from all specialities. This one opportunity exists in all settings, all wards, enhancing patient care and delivering excellence.

Leading innovation and improvement

207 TAKING PRACTICE TO THE PERIPHERIES ON NEURO-ICU

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10.1136/leader-2020-FMLM.207

Introduction Vasopressors are integral for the management of shock and haemodynamic augmentation. The early initiation of vasoactive treatment is associated with improved survival; however, the placement of a central venous catheter is identified as a barrier to the implementation of early goal-directed therapy. Considerations of initiating Noradrenaline peripherally raised concerns around complications including tissue necrosis as well as the potential for prescribing and administration errors. This caused persistent resistance for the change of management on critical care.

Aim Introduce peripheral administration of Noradrenaline on ICU (different dose, concentration, diluent and site).

Strategy of Improvement and Measurement: The project took seven months with approvals from the Drugs and

Therapeutics committee. Each risk reduction strategy created had ideas incorporated from medicines safety champions within the nursing, pharmacy and medical cohort. Feedback was taken on board, and processes adapted with staff being recognised for their contribution.

Results Type of shock

- Hypovolaemic/haemorrhagic: 40/50
- Cardiogenic: 3/50
- Septic: 7/50

Duration of infusion of Noradrenaline, Median (IQR)

- 30 hours (14,52)

Reason for discontinuation:

- Infusion changed to a central venous catheter: 9 (18%)
- Vasopressor no longer required: 38 (76%)
- Patient deceased: 2 (4%)
- Adverse effect (extravasation): 1 (2%)

Prescribing errors (diluent, dose, rate): 0%

Administration errors (diluent, dose, site, rate): 0%

Conclusion The initial challenge was resolved with the outcome being the nurses feeling empowered through knowledge of evidence-based medicine. This, in turn, resulted in a working force with excellent knowledge and approach towards pharmacological management, which further developed self-confidence in their capabilities and roles. The overall safety culture surrounding peripheral inotropes on the critical care unit has been enhanced.

Quality improvement

208

DEVELOPING FUTURE LEADERS THROUGH QUALITY IMPROVEMENT-THEMED WEBINARS

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10.1136/leader-2020-FMLM.208

Quality Improvement (QI) and leadership are increasingly acknowledged as basic training requirements across all healthcare professions. While UK medical schools are increasingly incorporating QI teaching into the undergraduate curricula, training opportunity is still limited for most healthcare students.

IHI St George's is an interdisciplinary student organisation that is a part of Institute for Healthcare Improvement (IHI) Open School network and is aimed at filling the gaps in the undergraduate curricula on QI.

The aim of the study was to educate and inspire healthcare students to participate in improvement projects.

Our objectives were 1) to assess students' baseline preparedness in conducting QI, 2) to design webinar series based on the feedback, and 3) to assess the effectiveness of webinars in teaching QI basics.

Methods Two webinar sessions were delivered live by junior doctors and recorded. Links to pre-and post-survey forms on Google Forms were sent to all attendees before and after the delivery of webinar session in September 2020. The topics covered the basic principles of QI, how to collect and analyse