Methods A retrospective review for our local maternity services was done for use of intravenous iron involving 24 pregnant women with iron deficiency anaemia. Cost of treatment was provided by the local business authority and the NHS Prescription Cost Analysis 2012 database.

Results 80% of patients received oral iron as the first line. However, there was inadequate evidence of antenatal counselling and checking compliance.

15 patients were treated with Monofer at a cost of £847 per patient. 9 patients were treated with Venofer at a cost of £2721.74 per patient.

On average women received Monofer later in pregnancy, 36 weeks compared to 31 weeks. In a small group of patients, mild adverse effects such as flushing and headache were seen with Monofer. However, these were self-limiting. Only one had severe HSR which was successfully managed.

No adverse reactions were seen in the Venofer group.

Conclusion Monofer replenishes iron stores faster than Venofer, offering a safe, convenient, cost-effective, single-dose therapeutic treatment for iron deficiency anaemia in pregnancy. However, it is not commonly used in pregnancy due to fear of hypersensitivity reaction. Simple adverse effects are mislabelled as hypersensitivity reactions. A management flow chart has been suggested after a multidisciplinary discussion to guide in case of such events.

There is a scope to improve detection of anaemia as well as the use of oral iron. To improve detection and management of iron deficiency anaemia, we have also introduced a simple flow chart for doctors and midwives to follow in hospital and community.

This study highlights being innovative, proactive and execution of ideas within wider multidisciplinary teams in community and hospital to improve patient experience, safety and management.

Think sugar

24 THINK SUGAR-HYPERGLYCEMIA MANAGEMENT IN CARDIOLOGY

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10.1136/leader-2020-FMLM.24

Introduction • Issue :Lack of awareness for the significance and management of hyperglycaemia in the short and long term for cardiology patients. Data collected from 21 inpatients in Cardiology ward and CCU between May 8th and 24th 2018, and 2nd cycle between 10th July till 30th July 2018.

Results

1. Hb A1C check (1st cycle showed on 33% which rose to 90% in 2nd cycle)
2. Reason for admission 1st and 2nd cycle: The most common reason for admission within the cohort was myocardial infarction.
3. Frequency of blood glucose checked: 1st cycle 67% patients checked 4 times a day. 2nd cycle this rose to 85%.
4. Referral to Diabetic specialist team: 38% were referred to the Diabetic inpatient team in first cycle which changed to 75% in the 2nd one.
5. Information given to the patients: 100% patients were given the information leaflet in the second cycle as compared to 42% verbal info in 1st cycle.

• Leadership and innovation: This QIP led to improvement in the understanding of healthcare professionals, about the significance of glycaemic control, patient information and appropriate follow up for it via following:

1. Catchy 'Think sugar' posters created and put up in cardiology ward and CCU, with literature references as part of evidence based medicine.
 2. First initial CBG check documentation was made part of nursing CBG check sheets.
 3. Patient information leaflet was created and feedback taken
- 6) Impact:

- Patient care and hence further admissions improved in terms of both cardiology care and glycaemic control and helped anticipating in reducing the health care burden as well.
- The innovative way of disseminating the knowledge and improving patient care helped health care professionals understand better the significance of good quality control as an integral part of cardiology related medical issues and overall health of the patients.

Enhancing your leadership and management skills

25 THE COVID JUNIOR SUPPORT TEAM (CJST)

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10.1136/leader-2020-FMLM.25

The NHS response to COVID 19 required staff to work very differently as the health service pivoted dramatically. As clinical service models evolved to prepare our hospital for the anticipated wave of COVID patients, a group of junior doctors who were excluded from frontline duties volunteered to contribute by providing office based tasks. The COVID Junior Support Team (CJST) was formed with its main 'objective', to support staff in the delivery of effective and high quality patient care. The CJST self-organised its members, taking on specific roles and setting up services tailored to address specific needs identified. Outputs included:

1. Standard Operating Procedures (SOP) for COVID-19 results management for discharged patients
2. Updating clinical guidance
3. Communication cascade
4. Rotas
5. Induction and Training programs for interim FY1's
6. Mortality Reports
7. Rapid learning reports/literature searches
8. Staff wellbeing survey
9. GP advice service provided by senior trainees and consultants

Our intervention has shown that despite not being able to work in patient facing clinical environments doctors in training have many transferable skills which can be harnessed to assist front line staff and contribute positively.

The CJST provided a unique development opportunity for doctors in training to gain experience of leadership and management across a wide range of activity. The team were