Method. The project proposed instating a 15-minute Zoom call at the start of each night shift (9:30pm) which involved the on-call team (SHOs, registrar, consultants and ideally bed managers). Firstly – a survey monkey questionnaire was sent to trainees to gain a baseline on how supported/informed/ease and learning opportunities for that shift. The project then piloted three separate Plan Do Study Act cycles of change and collected feedback from trainees after each cycle. Both qualitative feedback and quantitative feedback from trainees were collected in the Likert scale format after each PDSA cycle.
Result. Results showed that a key benefit of this call is that any pressing issues can be brought up and addressed. Furthermore, for the benefit of the trainees, generally trainees felt more supported whilst they are on call, and got to know the fellow on call team. In addition, trainees reported feeling more at ease when calling their senior colleagues.
Conclusion. It is particularly important for doctors to feel supported and informed during their on call shift, especially in the current climate, where there are fast changes and adaptations taking place due to the pandemic. By adding a short meeting at the beginning of each night shift, doctors in the hospital demonstrated an increase in feeling supported, informed and having educational opportunities during their on call shifts. In the long term, by addressing on call issues and making trainees feel more confident and supported during their shift, is likely to benefit and improve recruitment and retention.

Identification of patients with mood disorder following admission with hip fracture with a view to starting treatment and provide advice

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Aims. The aim of this quality improvement project is to improve identification and management of mood disorder in patients over 65 years admitted to Royal Surrey County Hospital (RSCH) with hip fractures by introducing a standardised assessment tool to guide appropriate interventions.
Background. The signs of depression in the elderly can be subtle and often go unnoticed. The multidisciplinary team (MDT) at RSCH observed that low mood could negatively impact on a patient's recovery, affecting pain thresholds and leading to poor engagement with rehabilitation. Proactive identification and management of mood disorder is an important part of Comprehensive Geriatric Assessment but not routinely performed in patients with hip fracture admitted to RSCH.
Method. Notes and discharge summaries of patients with hip fracture admitted over a four-month period were retrospectively reviewed to establish if patients were screened for low mood. A mood screening tool was chosen and implemented prospectively over a four-month period. Occupational therapists and junior doctors completed a Cornell Score for all patinets. Those identified with depression or probable depression were issued verbal advice, an information leaflet and follow-up arranged.
Result. Ninety-eight patients were included in the retrospective cohort. No patients were formally identified as having depression or probable depression, and there was no indication that mood was considered or assessed at any point during admission. During the four-month prospective period, 90 patients were admitted to RSCH with hip fracture and 86 patients (96%) were screened for low mood. Four patients were excluded due to a terminal prognosis. Of the patients screened, 9% had major depression and 16% probable depression. Feedback from our occupational therapists and doctors was positive, with the tool being relatively easy to use in patients with or without cognitive impairment. Much of the assessment could be incorporated into their initial assessment or in gaining collateral history from next of kin. Anecdotally, considering patients psychological wellbeing had a positive impact on inpatient therapy sessions guided the MDT in supporting the patient appropriately.
Conclusion. Implementation of a standardised and validated mood screening tool enabled us to identify that a quarter (25%) of the patients admitted following a hip fracture had, or probably had depression. This allowed us to intervene with simple measures such as verbal advice and an information leaflet and consider pharmacological intervention where appropriate.

"Beth": the development of a digital personalised health record and patient portal for use in clinical practice

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Aims. To design & develop a clinically scalable personalised health record and patient portal to;

Improve patient safety through improved communication and information sharing between staff, patients and carers, and improved access to safety plans for patients.

Increase the uptake of virtual appointments and video calls rather than over-reliance on telephone calls for clinical care

Empower patients to access supported self-management and self-directed care using digital resources
Background. Current mental health services often rely on telephone calls, letters, text messages and email, which often repeat information to the detriment of the patient. Likewise, care plans and appointments are given in paper cards, which can be lost or become out-dated. Furthermore, service-users often have no access to curated resources, symptom-tracking tools or ability to document their personal treatment targets in medical notes.
Method. Based on service-user feedback, clinical need and the above aims, a digital personalised health record and online portal was developed for patients to record personal goals & coping strategies, access crisis plans, view appointments, track symptoms, complete clinical assessments, communicate with their care-team and access self-management materials. The tool, 'Beth', was named after the Bethlem Royal Hospital and was launched in July 2020 to all patients in the South London and Maudsley Trust.
Result. Across the Trust, the tool currently has 710 active users. Features used include; accessing care plans and safety plans, communicating with care teams, organising and viewing appointments, undertaking clinical assessments to inform measurement-based care, tracking symptoms and progress, developing a secure diary, and accessing free & trusted self-management resources.
Conclusion. We have developed "Beth," a digital personalised health record and patient portal for use in widespread clinical practice. The tool allows patients to take an active role in their care-planning, enhances communication between patients, carers and clinical teams and may improve service efficiency and patient safety. Future development may customise the tool further to incorporate new features and optimise usability for patients and clinicians alike.

Wellbeing support for foundation doctors during COVID-19 in GHNHSFT

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Aims. The COVID-19 pandemic highlighted the importance of wellbeing amongst healthcare professionals. Medical professionals, notably junior doctors, are at increased risk of developing poor mental health and burnout. The GMC Barometer Study in 2020 showed that 32% of doctors found the first wave of the COVID-19 pandemic detrimental to their wellbeing and mental health.

The aim of this quality improvement project was to assess and improve hospital wellbeing support available to foundation doctors within Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) by learning and reflecting on the impact of COVID-19.

Method. After identifying a lack of resources within GHNHSFT, wellbeing information boards were displayed in communal areas and distributed by email. These encompassed trust wide support, practical information including childcare and relaxation resources concentrating on mindfulness, exercise and culture. A survey of foundation doctors was completed to assess doctors' focus and approach to wellbeing. Questions assessed influential factors in maintaining wellbeing, access to current hospital resources and future interventions.

Result. 94% of respondents recognised that their focus on wellbeing increased during COVID-19. One third of foundation doctors found it challenging to maintain their wellbeing, with 40% reporting difficulty accessing hospital support and advice. The most important factors foundation doctors identified in maintaining wellbeing were exercise, cooking and baking, and social networks. Colleagues were a significant source of wellbeing support, followed by notice boards, email resources and social media.

Conclusion. COVID-19 highlighted the importance and burden on wellbeing of foundation doctors, with a significant number struggling to access support. Future recommendations include the use of a 'buddy system', regular and accessible exercise classes and improved communication of wellbeing support and resources to staff members.

Buddy systems have already shown success amongst teams however it is important these are accessible to all foundation doctors and universally offered within the trust. A weekly yoga class is being reintroduced to be available to all doctors.

A particular focus has been the development of a health and wellbeing section to feature in the trusts weekly communications, with the aim to regularly signpost staff to ongoing wellbeing resources and support.

Social networking and media were highlighted as important in both maintaining wellbeing and accessing resources. A future goal is to develop an official GHNHSFT Instagram or Twitter account focused on wellbeing. We hope to continue to learn from the impact of COVID-19, improving the availability of wellbeing support at GHNHSFT that will continue into the future.

Audit on nursing notes in a psychiatry in-patient setting

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Aims. We aimed to assess the accessibility and informativeness of the content of daily nursing notes through an audit, and improve deficiencies identified.

Background. Nursing notes are an important source of observation findings, of in-ward psychiatry patients.

There can be variations in the quality of the notes as well as information contained within.

A basic level of clarity and information within all notes will be helpful in using these to inform the management of patients.

Method. An audit was carried-out in a ward treating working-age patients for psychiatric illnesses.

Setting standards - standard required of a daily progress note was decided after discussion in multi-disciplinary team meeting (MDT). Clear language and information on; mental-state, medication, meals, physical health, personal care, activities, risks and use of leave, were identified as requirements.

Retrospective audit - First audit cycle was carried-out by assessing the notes two weeks retrospectively. The assessment instrument used a qualitative measurement of the readability of the notes as well as quantitative assessment of the contents.

Intervention - The standards set during the MDT, as well as a suggested format for recording notes, were communicated to the staff through email. Follow-up meetings with individual staff members and MDT, to evaluate staff satisfaction and new suggestions to improve the format were held. Difficulties staff encountered when implementing the format were discussed and resolved.

Second audit cycle - Following implementation of the intervention, the notes were again assessed using the same instrument.

Conclusion. Difficulty in accessing information from the notes was noted in the first audit cycle. The average score for accessibility of information when scored on Likert scale + 3 to -3, was 1. Use of language scored 2 on average. On the second audit cycle, accessibility had increased to 3 on average while language score remained 2.

Quantitative measurement was done for presence of information on; mental state, medication, meals, physical health, personal care, activities, risks and use of time away from ward. All of these parameters showed an increase in the post-intervention second audit cycle. Information on taking meals, medication, and physical health was present 100% of the time in the second cycle. Most improvement was in information on personal care which showed a five-fold increase, from 17% to 89%

In conclusion, standard for nursing notes arrived via discussion and consensus in MDT, has been successful in improving the accessibility and information within nursing notes.

Special Interest- what are trainees doing in the West Midlands?

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Aims. The aim of this survey was to find out how Speciality trainees used their special interest sessions, using multiple choice and open questions

Background. The ST (Speciality Training) curriculum recognises that it is desirable that all higher trainees gain additional experiences that may not be available in their clinical placement. Two sessions every week must be devoted during each year of Speciality training for such personal development, which includes research or to pursue special interests. Special interest sessions are defined as "a clinical or clinically related area of service which cannot be provided within the training post but which is of direct relevance to the