measures included analysis of handover duration and a post-implementation staff survey to investigate staff perception and experience.

Results There is a sustained reduction in the length of the post-ward round handover from 94 to 35 min (10 days analysed pre and post-intervention). A qualitative survey found the following percentages of people agreed or strongly agreed that: job allocation is more robust and efficient (93%), handover is more efficient (64%) and there is improved patient 'ownership' (86%). 93% of respondents agreed that an active 'pause' at the end of the handover to ask questions or discuss staff and service issues was beneficial. The response rate was 14 out of 33 possible respondents (42%). A key finding was that the respondents unanimously agreed that facilitating a junior-led handover was empowering for trainees and turned a service safety task into a training opportunity.

Conclusion Empowering junior members of the team to hand over patients in conjunction with a series of small changes improved the effectiveness and efficiency of the medical handover. It also enabled a cultural change as handover was seen as a training opportunity in addition to being a service function.

G390(P) HOSPITAL AT NIGHT: OUR EXPERIENCES IN IMPROVING PATIENT CARE THROUGH ESTABLISHING A HAN TEAM

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Aims

- To set up a Hospital At Night (HAN) team and provide the facilities for effective working.
- To improve communication within the HAN team.
- To reduce interruptions to handovers and maintain handovers within the allocated timeframe.

Background The decision to establish a HAN team was taken following review of the medical cover of a 130 bedded quaternary paediatric hospital. Key issues were:

- A lack of effective team working and inadequate communication leading to workload imbalances and risk of important tasks being missed.
- A poor escalation policy leading to inappropriate escalation of deteriorating patients and patient safety issues.

Methods To address the issues we set up a multidisciplinary working group comprising: a consultant paediatrician, a paediatric registrar, a nurse manager and a nurse co-ordinator. These individuals underwent a peer consultation programme and the working group then met with other HAN teams throughout the region to learn from their experiences. Several audits and 'time in motion' studies identified specific issues which could be addressed. 48 Plan Do Study Act (PDSA) cycles were undertaken over an 18 month period with close collaboration and communication between our project group, senior clinical management and front line teams.

Results Funding was obtained for a specifically adapted 'HAN Room' which has become the team base for handovers, administrative work and breaks. Improvements within this room included: improved IT facilities, lockers, basic catering facilities and increased space. An updated escalation policy for deteriorating patients has been implemented complemented

with ward level teaching on identifying and managing a deteriorating patient for nursing teams. Interruptions to handovers have stopped and now 95% of handovers occur within the allotted time. Variation from this occurs appropriately due to discussion about complex or deteriorating patients.

Conclusion We have set up a successful HAN team and provided it with appropriate facilities. By doing this we have significantly improved communication, handovers, team dynamics and the team culture. The hospital co-ordinator working within the HAN team now provides an excellent link between the HAN team and the ward nurses.

G391(P) SCHOOL-BASED DIABETES CLINICS: QI TO ENGAGE FREQUENT NON-ATTENDERS AND IMPROVE TEENAGER'S SELF-MANAGEMENT

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Background Optimising attendance rates in outpatient's clinics is important to ensure good clinical care and to avoid waste of scarce medical resources. In 2016, we identified a cohort of 17 teenagers that frequently Do Not Attend (DNA) the Paediatric Diabetes Multidisciplinary Clinics, compromising patient care and reducing compliance with NICE and BPT standards. As this cohort was found to be enrolled in a cluster of 5 schools we explored the benefit of taking diabetes clinics into school.

Objectives Design and deliver additional school-based clinics to facilitate teenager's engagement with healthcare services.

Patients and methods During 6 months quarterly school-based clinics were offered to all teenagers with T1DM in these secondary schools. A semi-structured interview was administered to identify their concerns about diabetes. Patients were invited to provide feedback about hospital clinics. 34 teenagers were targeted (17 initially identified as frequent non-attenders and 17 controls at same schools).

Results The hospital DNA rate was reduced by 50%. HbA1c levels remained unchanged over the study period but school clinics allowed early identification of patients with rapid deterioration. School-based clinics improved teenagers' ability to express their real beliefs about diabetes and be actively involved in the management of their condition. This unveiled significant knowledge gaps not previously identified by the team in 50% of the participants. This clinic format improved communication and partnership with school nurses/health assistants, enabling healthcare plans to be more effectively carried out. Although patients were usually happy with hospital-based clinics, they complained about missing school, time spent in hospital and lack of privacy. Some teenagers perceived judgemental attitudes in healthcare professionals or parents.

Conclusions

- This pilot shows promise in improving contact in this difficult to reach group while reducing wasted hospital clinic slots.
- School clinics are an effective way to engage young people in self-management, actively preparing them for transition.
- A well powered trial may allow HbA1c improvement to be shown.