Abstract 3 Table 1 Overview of impediments to minimizing COVID-19 spreading in the ultra-orthodox population

| Impediments                              | Steps taken to address impediments                                                                                                                       |
|------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Logistical impediments                  | Establishment of a centralized government emergency management department for COVID-19 in the OUC.                                                   |
| Lack of ongoing communication and mutual updates by the government with the OUC | Daily phone calls to the mayor’s office and the local commander in charge, and periodic visits to every Ultra-Orthodox municipality.       |
| Difficulty in reaching PCR and vaccination sites | Mobile units and pop-up vaccination and PCR testing clinics in local community centers and even in city hall. |                                         |
| Vaccination and PCR testing adherence    | Distribution of ‘prizes’ to people who get vaccinated or get tested.                                                                                  |
| Inability to quarantine due to crowded households and poverty and food insecurity | Delivery of welfare-related activities tailored to the Ultra-Orthodox family’s needs (food baskets, games, books, and grocery shopping) to quarantined or sick families. |
| Transfer of COVID-19 positive patients to special recovery hotels that were culturally adapted for things like kosher catered food and holiday necessities | Enabling reopening of schools while enhancing specific guidelines that reduce risk of exposure and infection. Increased PCR testing of staff, mask-wearing, and physical distancing among both students and staff were instituted; shortening the school day and learning in shifts, outdoor learning, and/or integrated distance learning by phone were implemented when feasible and warranted. Daily monitoring of staff and student and rapid sampling of the entire class capsule when needed or closure of educational institutions with high morbidity rates. Collaborating with community and spiritual leaders/rabbis and physicians. Collaborations and empowerment of local governments/authorities. Targeted campaigns about vaccination and guidelines culturally adapted and targeted to the Ultra-Orthodox population. Specific guidelines (plans) related to detailed day-to-day Ultra-Orthodox life were written, including places or events with great religious significance such as synagogue attendance, visiting the Western Wall, holidays, and ritual baths. Approved guidelines were integrated into government guidelines and laws. |

Introduction

The Israeli Ultra-Orthodox community (UOC), a religious minority,1 was disproportionately harmed by the COVID-19 pandemic.2,3 The Israeli Ministry of Health (MoH) undertook a unique initiative to reduce COVID-19 transmission in the UOC by establishing a special task force (TF). This study analysed the initiative’s relevance to improving quality-of-health in the UOC.

Methods

The TF objectives were: (1) Formulating COVID-19 policy guidelines tailored to specific UOC needs and strengthening mutual trust between the MoH and UOC. (2) Reducing the spread of COVID-19 by increasing COVID-19 testing, establishing unique quarantine solutions and achieving a high vaccination rate. (3) Increasing adherence to the preventive measures and vaccination.

Close collaborations were developed with stakeholders in the UOC including: daily phone calls and in person consultations in all the UOC municipalities, weekly meetings with stakeholders: UOC leaders, military, police, government and others, and ‘behind the scenes’ meetings with influential rabbis.

Results

The TF activity has improved the effectiveness of COVID-19 prevention and quality-of-care for the UOC (see table 1 for an overview of steps taken to address impediments to achieving MoH goals). Improved accessibility to PCR-tests increased the number of tests. Welfare-related activities tailored to OUC needs such as food delivery to quarantined/sick families and recovery hotels helped increase adherence to quarantine and reduce COVID-19 spread. People from the UOC were recruited to facilitate the epidemiological investigations. This increased trust and resulted in more accurate results. Crafting detailed guidelines together with the community leaders resulted in increased public trust and compliance. The advocacy actions with influential rabbis led to high immunization rates in some cities.

Discussion

The establishment of a central headquarters that aims to promote health-policy that is customized and culturally sensitive was a lever to reduce inequality and improve quality-of-care in the UOC. This initiative demonstrated governments can increase trust with minority groups and potentially reduce health inequalities regarding other health issues as well.

REFERENCES


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Introduction

The organization (CNWL) has services in over 150 locations and tried multiple improvement approaches in the past (with limited success).
Can we embed improvement science across the organization in four years? Adopting a single methodology, focusing on co-production, data literacy, targeted training and a communication strategy to celebrate success.

**Methods** Our theory was, if we focused on the following four areas from the outset we would be successful at embedding improvement science.

1. Worked with service users and carers to design, develop and deliver our strategy
2. Changed how we use data (RAG reporting to SPC charts) in all board reports.
3. Developed a dosed training programme as well as targeting key influential leaders
4. Celebrated success, generated improvement stories and developed an annual conference with poster presentations and prizes

We also set ourselves a target of achieving 80% service user and carer involvement (in four years).

**Results** Some of our results:

- 2548 staff trained in QI methodologies (36% of the workforce)
- 64% of our QI projects now have service user and carer involvement
- 283 active projects
- 90% of our committee papers contain SPC charts
- Improved staff satisfaction and morale

Putting co-production at the forefront of our roll-out has changed the dial on service user/carer involvement across the organization with significant improvements demonstrated in previously difficult to improve areas. Our first ever annual conference attracted 430 people and 170 posters, evidencing previously difficult to improve areas. Our first ever annual conference attracted 430 people and 170 posters, evidencing our success, generated improvement stories and developed an annual conference with poster presentations and prizes

We also set ourselves a target of achieving 80% service user and carer involvement (in four years).

**Discussion** Co-production on delivery, design and implementation is pivotal to success. Nile Ward Psychiatric Intensive Care Unit, London, gives an example of how it used co-production to develop a set of mutual expectations between staff and patients to reduce violence on the unit. Developing bespoke training to meet needs of key staff groups has enormous impact. Prioritise embedding SPC charts into board reports from the start. In Making Data Count, S. Riley writes, ‘There is strong evidence that better decisions are made when using SPC rather than ‘simple’ techniques such as the popular RAG approach’. Opportunities for staff to share their work at a conference generates organizational enthusiasm for QI.

**REFERENCES**


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**5 PHYSICIAN PARTICIPATION IN QUALITY IMPROVEMENT WORK INTEREST AND OPPORTUNITY: A CROSS-SECTIONAL SURVEY**

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**Introduction** Lack of physician involvement threatens the success and sustainability of quality improvement work (QIW). Few studies have assessed physicians’ interests and opportunities to be involved in QIW. It is therefore important to do so, both in hospital and general practice.

**Methods** Our aim was to determine the prevalence of physicians reporting active participation in QIW and the prevalence reporting an interest (without participation) in QIW. To understand the potential for improvement, we also needed to assess whether physicians’ opportunity and designated time to participate in QIW had an effect on their interest and active participation in QIW. Our hypothesis was that designated time promotes participation in QIW. This resonates with Donabedian’s structure, process and outcome framework. We conducted a cross-sectional postal survey on a representative sample of physicians in different job positions in Norway in 2019.

**Results** The response rate was 72.6% (1513 of 2085). A large proportion (85.7%) wanted to participate in QIW, and 68.6% had actively done so in the last year. Physicians’ active participation in QIW was significantly related to the designated time for QIW in their work schedule (p<0.001). Only 16.7% reported designated time for participation in QIW. Among those with designated time 86.6% participated in QIW, while 63.7% among those without designated time participated.

**Discussion** Physicians want to participate in QIW. They participate to a higher degree when they have designated time. Leaders can increase QIW participation from physicians by ensuring that time for this is part of the work schedule.

**REFERENCES**


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**6 UNPLANNED MEDICINES-RELATED READMISSIONS TO MENTAL HEALTH WARDS AND CRISIS RESOLUTION HOME-TREATMENT TEAMS (CRHTTS)**

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**Introduction** Hospital readmission is common in mental health. Unplanned readmission within 30 days of discharge is considered a poor indicator of quality of care provided. In 2011, unplanned readmission rates for schizophrenia and