bed load, leadership and giving instant updates about guidelines and dissemination of critical information. Medic Bleep contributed to efficiencies in clinical workflow and may positively affect patient care.

Understanding leadership through research

119 WHY ARE THERE SO FEW MEDICAL CHIEF EXECUTIVES IN PSYCHIATRY? AN EXPLORATION OF THE PERCEPTIONS OF MENTAL HEALTH MEDICAL DIRECTORS AND CONSULTANT PSYCHIATRISTS

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Background Since the introduction of general management to the National Health Service (NHS), there has been a divide between doctors and managers which has prevented doctors from taking on management roles. However, there is evidence that clinicians, as managers produce better outcomes and doctors as CEOs, yield better results yet the number of medical and clinical CEOs remains small. The barriers and enablers for clinicians to leadership and management have been explored by the Faculty of Medical Leadership and Management (FMLM) but there is little research in psychiatry and the mental health sector.

Aims To gain insight into the experiences and perceptions of consultant psychiatrists and mental health medical directors on the barriers and enablers to leadership and management roles and the CEO position. To explore the recommendations of consultant psychiatrists and mental health medical directors on how to increase the number of medical professionals taking on leadership and management positions and the CEO position.

Methodology Eleven qualitative interviews were conducted with a combination of inductive and deductive questioning. Nvivo was used to organise codes. Braun and Clarke's six-step analysis was used for thematic analysis.

Findings Nine themes were found. Some echoed the findings from the research conducted by the FMLM. However, there were new findings specific to psychiatry related to demographics of the workforce including personality traits, higher BAME staff and a reaction against the traditional medical hierarchy which impact the ability of doctors to take on medical leadership and management roles.

Conclusion Many of the barriers and enablers found are similar to previous research so the recommendations from the FMLM report could be useful. New findings specific to psychiatry require further research to understand their impact and to determine their presence in other specialties.

120 IMPLEMENTATION OF A HYSTEROSCOPY USER GROUP AT SOUTHMEAD HOSPITAL, NORTH BRISTOL NHS TRUST TO ENABLE SUSTAINABLE EFFECTIVE CHANGE

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Background The Royal College of Obstetricians and Gynaecologists (RCOG) recommend the provision of an outpatient hysteroscopy (OPH) service by all gynaecology units. We run a high-quality OPH service at Southmead Hospital, however, increasing clinical demands drive the need to improve services.

Aims and Objectives We aimed to set up a multidisciplinary team (MDT) in OPH to identify specific areas where we could increase capacity and improve patient safety.

Materials and Methods We set up a MDT, entitled the 'Hysteroscopy User Group' (HUG) in the Gynaecology outpatient department.

A prospective efficiency flow- time audit was initially conducted analysing 36 patient journeys during an OPH appointment.

British Society of Gynaecology Endoscopy (BSGE) patient satisfaction surveys were undertaken to assess service quality.

Results The efficiency flow audit demonstrated the following averages times: three minutes for patient consent and three minutes for equipment set-up; eleven minutes procedure time; four minutes for patient debrief and overall thirty-nine minutes for the appointment.

BSGE patient satisfaction surveys showed 100% of responders classifying their treatment as good or excellent, with 94% of women stating that they would choose this treatment option in the future.

Interventions and Strategies for Improvement

We collaboratively identified specific areas for improvement including the introduction of RCOG consent stickers and nurse-led set up of equipment.

Capacity was subsequently increased by 40% thereby improving patient access to services whilst maintaining excellence in quality of care.

Conclusions and impact Formation of the multidisciplinary HUG improved capacity, transparency and communication across the OPH service; hence we were able to improve the quality of care we deliver to our women.

Change of symptomatic breast clinic during covid and into the future

121 LEADING CHANGE & THE EVOLUTION OF THE BREAST CLINIC THROUGH THE COVID-19 PANDEMIC AND INTO THE FUTURE

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The high transmissibility rate of Covid, obliged us to adapt and transform our symptomatic clinic to be able to continue diagnosing and treat breast cancer and at the same time protect patients and staff.

Prior analysis of clinical activity suggests at least 80 per cent of patient attending breast clinics are either healthy or found to have benign conditions, identification of this group of patients ahead of time would allow assess and treat them safely with a telephone clinic consultation instead

On this tenet we worked, in compliance to new and emerging guidance about breast cancer care during the pandemic from the Association of Breast Surgeons and the National Institute for Clinical Excellence, to devise a novel vetting system for stratifying and prioritizing all new referral to out-patient clinics.