Methods The service model was rapidly implemented using successive PDSA cycles and NHS model for improvement methodology; undertaking rapid redeployment of resources to include clinicians and PPE to dedicated respiratory hubs. This enabled increasing numbers of COVID positive patients and those with respiratory infections to be streamed towards dedicated respiratory hubs. Using clinical SystmOne community modules, remote booking was enabled to allow practices to book directly to a respiratory triage gateway. Senior clinicians were able to triage patients virtually while selecting those requiring clinical face-to-face assessments. This maximised already meagre supplies of PPE within primary care and provided the most cost effective solution. Exposure of patients and staff within the community was also minimized.
Results The service was both clinically effective and highly valued by patients, staff and physicians in primary care. We were also able to study prescribing behaviour and delivered an admission avoidance service protecting secondary care from inappropriate demand induced by the COVID-19 pandemic.
Conclusions We believe our methodology of implementation has proven the worth of integrated GP clinical systems and whole system integration via triage pathways that controlled patient flows towards the most clinically appropriate services during COVID-19 pandemic protecting secondary care services from being overwhelmed.

20 ESTABLISHMENT OF TELEMEDICINE FOR COVID-19 AFFECTED PATIENTS AT HOME ISOLATION IN A SECONDARY CARE HOSPITAL IN THE CONTEXT OF COVID-19 PANDEMIC

[1]Priyanka Suresh, [2]Santoshi Balkrishna Sinai Malkarnekar, [2]Vijaitha Parthasarathy, [2]Dipti Bidyan Kindo. [1]*Medical Officer, Department of Medicine, HAL Hospital, Bangalore, India*; [2]*Medical Superintendent, Department of Medicine, HAL Hospital, Bangalore, India*

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Aim Establishment of telemedicine for COVID-19 affected patients at home isolation in a secondary care hospital in the context of COVID-19 pandemic.
Methods While I was volunteering for the national telemedicine support for COVID-19 patients, a thoughtful implementation of the same in our hospital to help home isolated COVID-19 patients was made by our team. After seeking permission from the management, circulars were dispersed by means of hard copies and digital pamphlets to the employees' homes. We trained doctors in standard operating protocol, ethics and legalities of telemedicine and COVID-19 home isolation guidelines. Apart from these periodic meetings held to address the problems, regular feedback from doctors and the patients noted, COVID-19 case audits conducted, a nodal officer assigned for liaising between the hospital, patients and for primary contact tracing. All the tele-consulted patients information documented were updated to the local government bodies.
Results The whole process nurtured young leaders in the unprecedented times aiding the leadership to break barriers and adapt to function efficiently. Telemedicine transformed the patient-doctor relationship helping to build good rapport, became an efficient way of treatment and the patients accepted telemedicine as it was safe for their families.
Conclusion A leader's role in the healthcare system is to empower innovative solutions by fostering interaction and aiding quality patient care. We used the COVID-19 pandemic to transform a secondary care hospital into a more resilient system. Telemedicine was a ray of hope for distorted patients, challenged the perception of the existing practicing methods and skills. Telemedicine made counselling easier and helped to save many lives.

21 EVALUATING COVID-19 SURGE ROTA MODELS AND INVESTIGATING THEIR IMPACTS

[1]Laura Conway, [2]Saad Qutab, [3]Steven Fong, [2]Simon Merritt. [1]*Integrated Education, East Sussex Healthcare Trust, UK*; [2]*Respiratory Medicine, Conquest Hospital, UK*; [3]*Gastroenterology, Conquest Hospital, UK*

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Aims It is currently unclear which approach to staff management during Covid-19 disruption allows clinical practice optimization whilst ensuring junior doctor resilience. Our project aimed to provide an optimised surge rota at East Sussex Healthcare Trust during the second Covid-19 surge to improve workforce experience and to allow us to prepare for future surges while ensuring patient safety.
Methods A novel surge rota was developed alongside a diverse group of representatives with backgrounds in medical education, hospital management and general medicine. The new rota was more flexible and built on the regular 2016 Junior Doctor contract with the addition of supportive staffing and environmental changes. These included a variety of changes informed by the previous discussions regarding the rota used during the first surge. Improvement was measured during feedback sessions with individual doctors. Furthermore, qualitative and quantitative questionnaire data was gathered and analysed using descriptive statistics for presentation and summary.
Results Our results suggest the novel surge rota was an improvement upon other rotas used during the first Covid-19 surge. The main factors that affected this were: more senior and specialist support, timely consultant assessment of newly admitted patients, and extra locum cover. The novel rota facilitated more flexible workforce distribution, translating into improved overall junior doctor wellbeing throughout the surge.
Conclusions The identified rota tactics are recommended for future disruption and more can be understood on this topic. Open communication through hierarchies and disciplines is pertinent when synthesising diverse stakeholder opinions. A well-received surge rota is possible and rewarding, with improvements to be seen nationally. Moving forward, it is important to develop surge rota designs to improve resilience to chronic disruption, reduce burnout, and most importantly improve patient safety.

22 EVALUATION AND MODIFICATION OF MEDICAL HANDOVER USING TRAINEE FEEDBACK AND TECHNOLOGICAL ADVANCEMENTS

Rachel Swain, Ashu Handa, Sinthujah Balasubramaniam, Maria Capanna, Imrana Puttaroo, Josephine Fielding. *West London NHS Trust, UK (for all authors)*

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This project involved trainees and consultants working together on this project to transform on-call medical