increased ability to take breaks. However, the majority of doctors are still not exception-reporting missing breaks: 79% (2019), 74% (2020).

Lessons Learnt Whilst improved rest facilities were welcomed, this report recommends the maintenance of increased staffing levels and fatigue facilities during the recovery phase of COVID-19. The remaining £14,524.38 should be directed at creating shower facilities, upgrading computer hardware and sustaining the quality of KGH fatigue facilities. Lastly, the rate of exception-reporting must be increased through improving awareness, exploring alternative methods and supporting the action when necessary. The continual investment into rest facilities not only ensure workforce wellbeing but undoubtedly translates into the safety of our patients.

Geriatrics, community resources, student leadership, patient-driven research

58

AN INNOVATIVE PATIENT DRIVEN PROTOCOL FOR THE DEVELOPMENT OF A CRISIS PREPAREDNESS TOOLKIT: CMU-CARES [CRISIS AVOIDANCE FOR RURAL ELDERLY STAKEHOLDERS]

Brenda Varriano, Averie Dickinson*, Raha Mouzoon, Jacob Long, Ruoxi Lu, Andrea Beatty, Neli Ragina, Jyotsna Pandey. *Central Michigan University (CMU) College of Medicine, Mt. Pleasant, Michigan, USA*

10.1136/leader-2020-FMLM.58

The COVID-19 pandemic challenged society, requiring measures that impacted communities socially and economically. Rurally dispersed older adults [RDOA] have a greater number of health comorbidities, poorer finances and limited access to internet and community resources (e.g. healthcare specialists), leaving them more vulnerable in a crisis. Current guidelines are better suited to urban communities, neglect certain needs of RDOA, and are at times difficult to navigate/access due to their online formats. RDOA specific resources are warranted and development should involve stakeholders. CMU-CARES sought to develop an innovative protocol that would engage RDOA in the development of a crisis preparedness toolkit. CMU-CARES protocol consists of six stages. (1) Awareness by community-based outreach (e.g. mailed-letters, social media, community organizations) and participation from older adults in previous studies with the college of medicine. (2) Engagement occurred once a participant expressed interest. (3) Screening was completed at time of engagement. (4) Interviews/Interactions were modified from the WHOQOL-BREF and completed via Web-Ex online software to observe social distancing requirements. (5) Transcript analysis was completed with NVivo software to identify participant identified themes. (6) Design and development of a toolkit based on interviews. A target sample limited to 20–25 RDOA was used to reach data saturation. Presently 20 interviews have been completed. Preliminary themes include the need for timely and reliable information, training in use of technology and the need for social interaction. Overall, CMU-CARES is a novel person-centered project dedicated to improving well-being and healthcare outcomes in the vulnerable RDOA population during crises. It hopes to foster camaraderie between healthcare providers and the community while inspiring medical student driven research and fostering careers in geriatrics, primary care and public health policy.

Leadership lessons from across the world

59

TURNING ADVERSITY INTO OPPORTUNITY: UNDERGRADUATE LED IMPROVISATION IN TEACHING METHODS

Anvita Anne, Varun Kumar Bandi, Satyanarayana Murthy Pusuluri. *Dr. Pinnamaneni Siddhartha Institute of Medical Sciences and RF, Gannavaram, Andhra Pradesh, India*

10.1136/leader-2020-FMLM.59

Introduction There is a need for simple teaching methods every teacher can adopt, which are accepted by the students and provide a sustainable outcome. The traditional teaching methods do not achieve the desired outcomes, with many students left wanting for more practice of procedural skills.

Methodology MBBS Phase I students were randomly distributed into 3 groups: Group 1 (traditional method, n=30), Group 2 (Peyton's method, n=30) and Group 3 (Modified Peyton's method, n=30), and study duration was 6 months. Students were taught anatomy of the neck veins and were taught central venous catheterizations (CVC) into the right internal jugular vein by a single nephrologist on a mannequin. The modified Peyton's method consists of: Demonstration and Deconstruction, Comprehension, Performance and Observation, Teacher and Peer Feedback. The students were followed up with 4-week and 12-week recall.

Results The mean percentages obtained at end of 4 weeks in Groups 1, 2 and 3 were $82 \pm 10\%$, $86.67 \pm 7\%$, and $87.33 \pm 6.9\%$ respectively. The percentages obtained at end of 12 weeks were $74.5 \pm 7.6\%$, $80.5 \pm 7.5\%$ and $80.3 \pm 7.1\%$ respectively. There was a significant decrease in percentages in all the groups ($p < 0.001$).

At 4 weeks, there was significant difference between Groups 1 and 2, Groups 1 and 3 ($p < 0.05$), while difference between Group 2 and 3 was not significant. At 12 weeks, there was significant difference between Groups 1 and 2 ($p < 0.01$), Groups 2 and 3 ($p < 0.01$) while there was no significant difference between Groups 2 and 3. The number of students confident of performing the procedure in Groups 1, 2 and 3 were 30%, 56.7% and 60% respectively. There was significant difference in the confidence level between Group 1 and 2 ($p < 0.05$), Group 1 and 3 ($p < 0.05$), while the difference was non-significant between Group 2 and 3 ($p = 0.793$).

Conclusion This study highlights the effort of a student in turning her adversity into an opportunity to improve the educational methods.

Leading across systems and organisations

60

A JOINT EFFORT AGAINST COVID-19: LEADING A REMOTE REGIONAL TRAINING PROGRAMME AND COLLABORATING WITH THE BRITISH SOCIETY FOR RHEUMATOLOGY (BSR) ON A NATIONAL LEVEL

¹Yik Long Man, ²Dalia Ludwig, ³James Glanville, ⁴Louise C Pollard, ⁴Claire Gorman, ⁵Jaita Mukherjee, ⁶Victoria Logan, ⁶Gerald Coakley, ¹James Galloway. ¹King's College Hospital NHS Foundation Trust, UK; ²University College London Hospital NHS Foundation Trust, UK; ³Lewisham and Greenwich NHS Trust, UK; ⁴Homerton University Hospital NHS Foundation Trust, UK; ⁵London North West University Healthcare NHS Trust, UK; ⁶Education and Trainee Committee, British Society for Rheumatology, UK

10.1136/leader-2020-FMLM.60

COVID-19 has had a significant impact on specialty training. All training days were cancelled and the majority of trainees were redeployed to general medicine.

By early May 2020, there was a shift in the focus back towards specialty training as COVID-19 related hospital admissions continued to decrease. With the help of the team from King's College London, a remote rheumatology training programme was developed and accessible to trainees from four different regions – South London, North West London, North East/North Central London and Kent/Surrey/Sussex. The collaboration between different regions gave access to a greater pool of speakers and reduced the administrative workload. Subsequent collaboration with the British Society for Rheumatology facilitated the delivery of the webinars on a national level, supporting other regions that had not yet set up any remote training.

Feedback was particularly important for this innovative programme in order to understand how this experience could be optimised for trainees. There were no additional difficulties related to the training taking place online, with one trainee responding that it was 'very easy to log on'. There was also positive feedback regarding the recording – '[it] was great to have a link to the recording to watch it later'.

By having a shared vision for change, we were able to work across regions and organisations, delivering a high quality training programme on a national scale, benefitting a greater number of trainees. Remote training has the additional benefit of removing the need to travel between hospitals. Therefore, there may be a push towards blended learning (a combination of online and face-to-face learning) in the future. Using a robust feedback mechanism, we are confident that the programme will continue to improve as it evolves alongside the pandemic, aiming to at least in part, satisfy the speciality rheumatology training needs within our regions.

Understanding leadership through research

61 FAMILY HEALTH STRATEGY AND HEALTH EQUITY AMONG OLDER ADULTS

Marciane Kessler, Elaine Thumé, Michael Marmot, James Macinko, Luiz Augusto Fachini, Fúlvio Borges Nedel, Louriele Soares Wachs, Pâmela Moraes Volz, Cesar de Oliveira. Department of Postgraduate Program in Epidemiology, Federal University of Pelotas, Pelotas, Brazil, Department of Postgraduate Program in Nursing, Federal University of Pelotas, Pelotas, Brazil, Department of Epidemiology and Public Health, University College London, London, UK, Department of Community Health Sciences and Department of Health Policy and Management Departments, University of California, Los Angeles, EUA, Department of Public Health, Federal University of Santa Catarina, Florianópolis, Brazil, Department of Public Health, Federal University of Rio Grande, Rio Grande, Brazil

10.1136/leader-2020-FMLM.61

People living in low social conditions have higher morbimortality risk and lower access of health services. Primary Health Care (PHC) has been recommended as the main strategy to achieve the goal of health for all. Since 1994 the Brazil MoH proposed a new strategy PHC called Family Health Strategy (FHS), to reorganize and restructure the universal health system. FHS was implemented first in the poorest and less assisted areas, to reduce health inequalities. FHS has been associated with improvement in health indicators; however,

there is little understanding about how it affects social inequalities. Therefore, we compare the mortality among older adults living in areas covered by FHS to those not covered by them. We believe that there is no difference in mortality between these two groups, given that FHS could be able to minimize the impact of social inequalities among the poorest. These are results from 'The Bagé Longitudinal Study of Ageing'. In Bagé, half of the population and sample was covered by FHS at the baseline study (2008), it means, the poorest areas/periphery of city. This context makes our study a natural experimental research. All interviewed at baseline (1,593) were eligible for a follow-up. 1,336 (83.9%) older adults were located in 2017; 579 deaths were confirmed (53.5% in FHS). We used X2 to compare proportions, cumulative survival curves adjusted for age-sex and Log-rank test. Results show a significant higher prevalence of participants with low wealth, skin color black/brown/yellow/indigenous and less school living in FHS areas, compared to TPHC areas, as expected. Hence, people living in FHS areas present higher prevalence of health conditions, as smoking, diabetes, depression and disabilities compared to TPHC, confirming the impact of social determinants. However, we confirm our hypothesis; no difference was found in all-cause mortality risk between FHS and TPHC during 9 years follow-up.

Leadership lessons from across the world

62 CREATING AND SUSTAINING AN EXPERT FORUM ON NONCOMMUNICABLE DISEASES IN LOW- AND MIDDLE-INCOME COUNTRIES

Kannan Subramaniam, Barrett Jeffers, Anurita Majumdar, Shekhar Potkar. Research Development and Medical (RDM), Upjohn, Australia, RDM, Upjohn, USA. RDM, Upjohn, Singapore. RDM, Upjohn, UAE

10.1136/leader-2020-FMLM.62

Aims Noncommunicable diseases (NCD) cause 71% of all deaths worldwide. More than 85% of premature deaths (ages 30–69) occur in low- and middle-income countries (LMIC).] LMICs are not on target to achieve the United Nations' Sustainable Develop Goals (UN SDG) 3.4. The aims were to create a multi-stakeholder forum to review NCD burden in LMICs; consider pragmatic solutions; and lead the conversation to inform the broader agenda on NCDs.

Methods As key health stakeholders, medical leaders in Upjohn invited others to form an Expert Forum on NCDs in LMICs. These experts in clinical practice in primary and specialty care; academic research; patient advocacy; community pharmacy; public and health policy; civil society; mobile health; and private industry were chosen because they worked in LMICs; published peer-reviewed papers; committed to act together on NCDs.

After an accelerated development sequence through storming, forming and norming, we commenced reviewing the NCD burden and challenges to overcome it. Through facilitated workshops, the team articulated how different sectors could, together, generate concepts for systemic solutions.

Results The 19-member team has published a paper in a peer-reviewed journal that reviews the NCD-burden in LMICs; captures the rich workshop dialogue; presents the evidence and posits pragmatic solutions to combat the burden. Team