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

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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

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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

members have further led the conversation through abstracts at international conferences and opinion editorials in key media, and communicated them via social media.

Conclusions Private and public health sectors can indeed work together to lead the conversation on change. More partnerships may catalyse regional responses to address NCDs. On downstream efforts we included patients; a rewarding experience that embraced 'nothing for us without us'. Next time, we would engage with government stakeholders and multilateral organisations. No one can afford to be a bystander; but we cannot do it alone.

Leadership opportunities for junior doctors

63 COVID AS A DRIVER OF CHANGE: LEADERSHIP OPPORTUNITIES TO IMPLEMENT NOVEL WAYS OF WORKING IN THE SURGICAL ASSESSMENT UNIT OF A DISTRICT GENERAL HOSPITAL

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10.1136/leader-2020-FMLM.63

Introduction Covid restrictions provided opportunities for novel approaches to patient assessment in the right place at the right time, whilst minimising unnecessary footfall in the Surgical Assessment Unit (SAU) of a UK District General Hospital. Prior to the pandemic, referrals were taken by Nurse Coordinators. Increasing call volumes put pressure on the department & disrupted clinical duties.

Referrers often expressed difficulties in contacting SAU.

'Hot Clinics' (HC) reviewed patients attending the Emergency Department (ED) who did not require admission.

Shielding Registrars led an innovative approach to triage SAU referral calls from General Practitioners (GP) & Nurse Practitioners (NP).

Aims To give Registrars an opportunity to innovate & lead service development through a novel way of working to triage SAU telephone referrals.

Methods Referral calls were diverted for triage by the hospital switchboard. Three outcomes were offered: Clinical advice, HC appointment or SAU review.

Prospective referral data (15/6–31/7/2020) & retrospective non-triage data (15/6–1/7/2019) were gathered. Triage effects were measured by outcome comparison with non-triage data.

Questionnaires were emailed to stakeholders.

Results From 15/6–1/7/2019, 56% of patients reviewed in SAU were sent home & 44% admitted, compared to 23.6% & 28.1% of referrals during the 2020 study period. Furthermore, 28.4% of admissions were avoided by triage.

Only 3.1% of patients triaged presented to ED within 7 days. Triage reduced disparity in admission rates for GP & NP referrals (53.6% & 16.2% in 2019, compared to 29.1% & 26% in 2020).

HC availability was limited. In view of reduced admissions, expanding this may prove cost neutral. Triage was popular with stakeholders.

Data will inform the Integrated Front Door project, to shape future development of Emergency Care.

Conclusions Traditional ways of working should be challenged. Novel approaches can be cost effective & positively impact patient care.

Leading innovation and improvement

64 COVID-19 PANDEMIC DOCTOR BLEEP SYSTEM

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10.1136/leader-2020-FMLM.64

Background Communication is key in all aspects of clinical medicine and the doctor's bleep system is vital in ensuring staff members can communicate with the right people. During the unprecedented times of COVID-19, the medical doctors at Eastbourne District General Hospital (EDGH) commenced a 'surge rota' consisting of 4 days on, 4 days off. I aimed to review the bleep system to assess whether ward and medical staff could easily contact the relevant doctor and to introduce and distribute a new 'bleep system' which may in turn, enable a safer and smoother running of the hospital.

Methods A cross-sectional study of all doctors on the 'surge rota' (April 13, 2020, and May 31, 2020) at EDGH was obtained. The primary outcome measure was their responses to a survey pre- and post-initiation of the 'bleep system.'

Results A total of 32 doctors responded to the survey. Following initiation of the 'bleep system' the ease of contacting a specific doctor, increased from 18.75% to 93.75%. Similarly, medical staff knowing which bleep to carry (18.75% to 87.5%) and nursing staff knowing who to reliably contact (9.38% to 75%). Doctors also reported being bleeped less often regarding issues not related to them (84.38% to 46.88%) and if they were contacted inappropriately, they knew who to forward the issue on to once the system was in place.

Conclusions The bleep system is one of the only ways to contact a doctor. Therefore, it is both empirically important and essential for a robust system to be in place which enables both patient safety within the hospital and the smooth running of our NHS service. During COVID times, I implemented a more robust system than its predecessor. Future recommendations should focus on formalising and standardising an effective bleep system throughout EDGH both during the pandemic and beyond.

65 JUNIOR DOCTOR ENGAGEMENT IN ROTA WRITING DURING THE COVID 19 CRISIS

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10.1136/leader-2020-FMLM.65

The COVID-19 pandemic placed an unprecedented demand on the NHS. In response, high-intensity rotas were implemented with short notice. This project aimed to fairly and safely step down the COVID response rota as normal working patters resumed.

Assessment A cross-sectional survey was distributed to doctors on the medical COVID rota. It explored their views on the step-down process. The majority of respondents (68%) had concerns including discrepancy between on calls and lack of opportunity to plan leave. A document of key themes in the feedback was prepared and presented to senior clinical managers.