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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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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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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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.

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