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 patterns 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.

Intervention and Improvement The new rota produced ensured an even distribution of shifts and honoured pre-existing leave. The new rota was compliant and ran to completion for every trainee. Comparison of stepping down to the trust rota vs our new rota reduced inter-trainee shift variation. Night shift discrepancy SD reduced from 2.89 to 0.97, long day (ward cover) on-calls reduced from SD 3.57 to 1.12 and long day (take) shifts SD 0.98 to 0.56.

Following implementation a second cross-sectional survey was distributed. 85% agreed or strongly agreed that there was sufficient staffing levels 'on call' and 80% agreed or strongly agreed that there was sufficient staffing levels on the wards. 95% found they were able to take their annual leave and 80% agreed or strongly agreed that there was an even distribution of on-call and night shifts.

Conclusion The success of our project relied on good engagement with colleagues to collect a representative view for leverage in discussions with seniors, and produced a result that was fairer for trainees, sustainable, and preferable for rota coordinators and senior clinical management. Active collaboration in the rota design process will improve junior doctor engagement, well-being and job satisfaction.

Leading innovation and improvement

66 PRIMARY CARE: CHALLENGES FACED DURING COVID-19

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10.1136/leader-2020-FMLM.66

The COVID-19 outbreak is arguably one of the greatest public health challenges of our time - not least for general practice, where over 1 million patients are already treated daily. Boundary House Medical Centre, a GP practice in Greater Manchester, has a 10,500 patient population and 28 members of staff. As lockdown approached, the transition in primary care in such a short space of time presented many challenges, particularly for those in leadership positions (practice manager (PM), GP partners). This project sought to capture the experiences of the staff at the practice to highlight lessons learnt during the pandemic in primary care.

Using a semi-structured format, interviews were conducted in July 2020 of all staff members at the practice. This involved the PM, 3 GP partners, Salaried GPs, GP trainees, trainee advanced practitioner, Nurses, HCAs, and the rest of the diverse administration team (n=28). Their responses were summarised into transcripts using an interview-based format. Consensus coding of the transcripts was performed using thematic analysis to establish common themes during the interviews and how this related to staff well-being.

This project highlighted some key learning points in primary care during the Covid-19 pandemic. It challenged leaders to be adaptable during uncertain periods, keeping staff engaged and up to date, and fostering a feeling of togetherness in a collective aim to still provide excellent patient care. Leaders felt empowered with more individual autonomy and there was a greater focus on staff wellbeing through both the creation of an environment which makes staff feel safe, valued and supported, ultimately improving staff well-being and morale.

67 COORDINATING ADVANCED CARE PLANS FOR PATIENTS IN NORTH WEST LONDON

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10.1136/leader-2020-FMLM.67

Background Care home residents account for 185,000 emergency admissions each year, with 35–40% of these potentially avoidable. Coordinate My Care (CMC) is a validated tool which enables patients to hold a digital advanced care plan. Effective use of this tool prevents unnecessary admissions and provides better care in the community. This project assessed the understanding of advanced care plans and promoted the use of CMC as tool to enhance this process which in turn will lead to less avoidable emergency admissions, particularly in the elderly.

Assessment A quantitative survey was conducted to evaluate the understanding of the importance of advanced care plans. The survey included doctors and other allied healthcare professionals working in the Medicine for the Elderly Department at St Mary's Hospital. The results show that of the 21 doctors only 19.05% had access to CMC. In addition nurses, occupational therapists and other allied health care professionals within the department did not have CMC access.

Intervention Numerous departmental teaching sessions were conducted where we discussed the evidence of how effective plans can prevent unnecessary admissions and ensure frail patients with end of life care needs die in their preferred place of death. Training was provided on how to access and complete advance care records using CMC. We provided login access to enable the users direct access to CMC through the electronic health care record, which has single user sign on facility.

Conclusion Advanced care plans are an integral part of improving care. We promoted a digital solution to enable effective data sharing between primary and secondary care, London Ambulance Service and community services. This tool will help reduce avoidable admissions for the vulnerable and ensure patients are cared for in their preferred place of death when they reach the end of life.

Enhanced recovery following elective caesarean section

68 A QUALITY IMPROVEMENT PROJECT TO ENHANCE THE RECOVERY PATHWAY FOLLOWING ELECTIVE CAESAREAN SECTION AT ST THOMAS' HOSPITAL

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10.1136/leader-2020-FMLM.68

Aims Our project aimed to enhance the recovery pathway for elective caesarean section (ELCS) at St Thomas' Hospital by reducing the length of stay by 20% by February 2020 (over a course of 5 months).

Methods Quantitative and qualitative data (via feedback forms) was sought. The length of stay following ELCS was calculated from theatre operating times and discharge time