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

obtained via BadgerNet. The baseline data was collected for 4 weeks in September 2019 and the project ran until February 2020.

ELCS journeys were shadowed, gaining exposure to patient and staff experiences. This revealed that the 'to take out medication' (TTO) pathway was a major contributor to discharge delays and therefore interventions were devised forming three Plan-Do-Study-Act (PDSA) cycles. The first intervention and PDSA cycle consisted of poster and email reminders for junior doctors to increase TTO prescription efficiency. The second saw maternity support workers (MSWs) collect TTO medication from the central pharmacy twice daily at 2:30pm and 4:30pm. An additional collection time of 6pm was added for the third and final intervention.

Results The baseline median length of stay of 51.2 hours decreased to 47.4 hours after all interventions. We did not reach our goal of less than 41 hours (20% reduction from baseline). The results, however, are very promising with 59.8% of patients (137 of 229 patients) staying a duration less than our baseline median hours of 51.2.

Conclusions Our activities altered the logistics of TTO delivery leading to earlier discharge and are easily reproducible and could be beneficial throughout the hospital setting. The benefits include more positive experiences for women, improved recovery, reduced departmental costs and bed demands. Identifying problems and collating feedback from stakeholders was essential to our success and should be undertaken by those in management before making changes.

Leading innovation and improvement

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CO-ORDINATING CRITICAL CARE TRANSFERS: CREATION OF AN ICU TRANSFER HUB

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10.1136/leader-2020-FMLM.69

COVID-19 hit North West London (NWL) early, placing unprecedented and uneven demand on its Intensive Care Units (ICUs). It became clear that high volume inter-hospital transfers would be required to dissipate capacity pressures across the region and prevent units from becoming overwhelmed. However, ICU transfers are highly complex, requiring specialist teams and intensive coordination – resources that individual units could not spare – and to perform this at scale presented a real challenge.

In response, the North West London Critical Care Network (NWLCCN) rapidly created an ICU 'Transfer Hub' to coordinate the strategy and logistics of capacity transfers. It was staffed by three doctors who communicated closely with ICU leads for real-time metrics on the fluctuating capacity pressures to plan the volume and destinations of patient transfers. An emergency bank of stand-by transfer volunteers was created, consisting of 69 critical care clinicians from across London, and the Hub partnered with a staff-bank management app to create a bespoke digital platform to facilitate shift scheduling and payment. This automation

provided a way to onboard new staff swiftly and scale the bank with ease.

Between 17 March - 6 May 2020, the Hub coordinated the transfer of 238 patients, at its peak organising 13 patient transfers in a single day – the highest frequency of ICU transfers ever carried out in NWL.

These inter-hospital transfers were essential for NWL to cope with pandemic-driven ICU admission pressures and created greater equity of access to critical care for patients. The strengths of a network uniting to deliver mutual aid were maximised by having a single hub as the conduit to support information flow and co-ordinate decision making. Partnering with a tech platform and having access to key decision-makers were other enablers that allowed the Hub to innovate at pace and their experience has informed discussions about developing a pan-London ICU transfers service.

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DEVELOPING A CLINICIAN FACING METRIC DASHBOARD TO FOSTER SELF DEVELOPMENT AND PERSONAL IMPROVEMENT IN PRIMARY CARE

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10.1136/leader-2020-FMLM.70

Aims Improving a clinician's ability to review their performance, and providing the tools to grow is fundamental in enhancing professional development at any stage. Once clinicians complete training, that review ability diminishes. Clinical pressures can mean opportunities to review one's practice is limited or subjective. Our aim was to use the technology driving our digital platform to provide clinicians with real-time data enabling them to have meaningful reflections and discussions.

Methods Working with data analysts we developed individual secure dashboards for clinicians to access information. This involved analysis across multiple metrics including patient ratings, coding, prescriptions, referral rates, notes audit scores, time in consultation and time taken to complete a consultation post patient interaction. A management tool was created to allow clinical leadership to confidentially access data to support clinicians during discussions and to help set development goals.

Results The dashboards have been released and we aim to monitor utilisation over the next 3 months. We plan to gather feedback at regular intervals including features clinicians feel would be helpful to them. Using a set of volunteers we can review the impact of direct intervention e.g. education and training courses, to see if a clinician sees improvements. Direct intervention to support clinicians can be monitored (with clinician consent) to see if teaching and training strategies work practically to help them.

Conclusions Clinicians should be involved in every step in this type of project and their feedback is key. This should be driven from the ground up and led by those who will use the tool to ensure that it reflects the workforce needs. We believe this level of personalised information and data will assist with self-management and development. Clinicians should use this for their own benefit and in no way should it be used by leadership as a means to monitor individuals directly.