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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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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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.