consultant to consultant. A survey was sent to all staff after the 12 weeks enquiring how it affected morale, the treatment of critically ill patients and how much sick leave was taken in this period. Fifty of sixty people responded to the survey.

**Results**

Over 12 weeks not a single day of sick leave or isolation was taken. 84% of responders felt the watch system improved morale. 90% agreed it improved the treatment for critically ill patients. 88% want to return to the Watch system if a second wave of COVID-19 occurred. 86% agreed it improved communication and teamwork. 96% agreed the presence of a senior doctor 24h/day had a positive effect on the running of the department.

**Conclusion**

A watch based system improved patient and staff safety whilst simultaneously improving staff morale and teamwork during the first wave of COVID-19 at Jersey General Hospital.

### Leading Innovation & Improvement

**CARE NAVIGATION IN PRIMARY CARE: A STUDENT-LED CLINICAL AUDIT & QUALITY IMPROVEMENT PROJECT**

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**Aims**

Aims included assessing the need for a care navigation intervention and creating a tool to help patients access care more efficiently. Further objectives were developing leadership and management skills as medical students and pursuing a role in service evaluation and improvement within the practice.

**Methods**

GP at the practice were experiencing a high demand for telephone consultations as well as face-to-face appointments. Although some were reserved for same-day booking, elderly patients were often disadvantaged due to the need to call early for an appointment. 110 triage telephone consultations were analysed which suggested that 43% of calls were misdirected, with pharmacists being the most overlooked alternative. A patient education flowchart was developed and presented to 9 patients to raise awareness of alternative healthcare providers and appropriate reasons to book appointments. Feedback was evaluated using questionnaires.

**Results**

Although all patients were aware of some services pre-intervention, 89% said they were more aware of others post-intervention. Some patients suggested having services like Women’s Aid in the flowchart and having it both online and in-person.

**Conclusions**

The needs analysis showed how education can help direct patients to appropriate healthcare providers. The flowchart was successful, but dissemination will be vital in future. Incorporating patient education into appointments may improve efficiency and the primary care network (34k people) intend to circulate the diagram. Care navigation benefits both practices and patients – potential benefits being patient satisfaction, empowerment and efficiency. Further, it may relieve GP workload and boost morale. The medical students involved also developed research and leadership skills by using quality improvement methodology. Leadership and management are vital for service improvement and there is great advantage to medical students designing and leading quality improvement projects.

**Trainee led trainee-programme creation**

**WICKED PROBLEM? TRAINEES CREATING A NOVEL FOUNDATION INTERIM YEAR 1 (FY1) PROGRAMME AT SOUTH TEES NHS FOUNDATION TRUST**

Mohamed Nauzan Mohamed Nazeer, Bill Kawai-Calderhead, Matthew Jones. James Cook University Hospital, Middlesbrough, UK

**Aims**

Trainees utilised as clinical leaders. FY1 pastoral and welfare support.

**Methods**

FY1s and Trust’s needs were initially unknown. Echoing military planning and the Wicked Problem concept, tutors used question-based planning which identified 5 domains: operational; pastoral; educational; administrative and exit. The programme’s centre of gravity, and therefore critical needs, were established in educational and pastoral domains. A voluntary evaluation of the domains by FY1s gauged programme quality.

**Results**

Median score for programme quality was 9/10 (mode 10/10). Median and mode for pastoral and welfare support was 10/10. Median scores for teaching and clinical supervision was 8/10. The lowest scores were 6/10 for quality of clinical supervision (n=1) and quality of pastoral support (n=1).

**Conclusion**

The programme provided a highly impactful and positive experience for FY1s; qualitative responses showed increased levels of confidence due to enhanced clinical learning opportunities in a well-supported environment.

**Leading innovation and improvement**

**MANAGEMENT OF PATIENTS WITH DIABETIC RETINOPATHY**

Christos Iosifidis. Barts and the London School of Medicine and Dentistry, UK

**Aim**

The purpose of this study is to audit compliance against recommended guidelines for follow-up of patients with DR by the Diabetic Retinopathy Screening Service at the Church Road Health Practice in East London. Comparison is made...
with data from a previous audit conducted between 2016 and 2017.

Methods 208 patients with DR were identified on EMIS between 2018 and 2019. They were then classified according to DR grade and time from last screening to most recent follow-up eye examination within 12 months, 3–6 months, 4 weeks, and 1 week. Moreover, data is shown for HbA1c value and type of diabetic treatment.

Positive results:
1. Did-Not-Attend numbers for DRSS decreased significantly since last audit.
2. All patients were seen within the appropriate time scale for retinal screening/hospital review.

Negative results:
1. For those who DNA, there were no reasons noted on EMIS and no communication between the Practice and DRSS to clarify the reason.
2. 67% of patients with DR had poor diabetic control and needed up-titration of their treatment or to start on insulin.

Conclusion Results show that changes in clinical practice are needed to ensure proper follow-up of patients with DR. Changes recommended focus on better communication and more efficient and effective time spent on Diabetes management. A few solutions include:
1. Phone calls between the practice and DRSS to clarify reasons for DNA
2. More frequent visits (3–6 months) for patients with uncontrolled HbA1c
3. Up-titration of treatment over the phone without the need of a GP appointment for patients not on maximum number and dose of oral medications.
4. Patients to be reminded during their Diabetic Annual Review to book for retinal screening.

Quality improvement

INNOVATING TO IMPROVE: REDESIGNING EMERGENCY ORTHOPAEDIC FRACTURE CARE DURING A GLOBAL PANDEMIC

Thomas Cash, Nastaran Sargazi, Cefin Barton, Nicholas Boyce-Cam. Mid Cheshire Hospitals NHS Foundation Trust, UK

Aims The COVID-19 pandemic has changed the delivery of emergency orthopaedic fracture care, with focus on avoiding hospital admissions and minimising nosocomial virus transmission. We set out to reconfigure our service to best meet the needs of patients.

Methods Prior to the pandemic, patients with displaced fractures requiring manipulation routinely received treatment in the operating theatre. The pandemic posed several challenges to the continued delivery of this service following a reduction in theatre capacity. After discussion with multidisciplinary team members, it was agreed that where possible manipulations would be performed in fracture clinic at the point of the presentation. To facilitate this, the trust’s mini c-arm (fluoroscopy) was relocated. A standard operating procedure (SOP) was written to guide safe administration of analgesia for adults and children. Essential resuscitation equipment and airway trained doctor support were made available to ensure patient safety. Data was collected prospectively over a 28-day period and compared to the same period in 2019.

Results The mini c-arm was used on 34 patients in the fracture clinic setting. 82.4% patients received definitive treatment and 44.1% avoided admission for theatre. There were no adverse events. Compared to 2019, the number of patients undergoing fracture manipulation in theatre decreased by 66.7%. NHS reference costs were used to estimate a £8445 saving over the 28-day period.

Leadership Lessons The nature of the global pandemic required swift action to be taken to adapt our service to meet the needs of patients. We used the PDSA (plan, do, study, act) framework to implement this change. After discussion of the findings at our quality improvement meeting, an SOP has now been written to guide the continued running of the service. We wish to highlight this model of emergency orthopaedic fracture care to other trusts for use in the COVID-19 pandemic and beyond.