

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

### 98 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** GPs 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

### 99 WICKED PROBLEM? TRAINEES CREATING A NOVEL FOUNDATION INTERIM YEAR 1 (FIY1) PROGRAMME AT SOUTH TEES NHS FOUNDATION TRUST

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The FiY1 cohort was nationally implemented to bolster an already pressured health-service for the COVID-19 pandemic. Existing trainee programme templates (such as Foundation Year 1) were inapplicable. Realising this a volunteer team of trainees stepped-up to create a bespoke programme for the Trusts 43 FiY1s.

**Aims** Novel programme creation.

Trainees utilised as clinical leaders.

FiY1 pastoral and welfare support.

**Methods** FiY1s' 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 FiY1s 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 FiY1s; qualitative responses showed increased levels of confidence due to enhanced clinical learning opportunities in a well-supported environment.

Clinical leadership routinely is hierarchical and repetitive. Creation and execution of this programme in non-routine times highlights the need for flexible, agile and innovative clinical leaders. The 5 domains are applicable to any educational programme creation enabling focussed and detailed needs' analysis and planning.

Lessons learnt 1. Question-based planning effective in novel challenges 2. Trainees are capable of competently executing at operational and tactical levels in a trust 3. Organisations should encourage such opportunities for trainees but reciprocally need to provide guidance and support.

## Leading innovation and improvement

### 100 MANAGEMENT OF PATIENTS WITH DIABETIC RETINOPATHY

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**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

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

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**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.

## Quality improvement

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### IMPLEMENTING POSITIVE CHANGE TO THE PRESCRIBING SYSTEM ON THE RENAL WARD IN NINEWELLS HOSPITAL

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10.1136/leader-2020-FMLM.102

**Introduction** Staff on the renal ward in Ninewells Hospital have highlighted multiple prescribing errors affecting haemodialysis inpatients. Currently, they have two drug charts; one for the acute hospital admission and another for dialysis medications. Concerns were highlighted after duplicate antibiotic doses were administered out of hours, due to confusion surrounding two drug charts. The aim of this project was to reduce the number of drug chart errors by 50% departmentally, in keeping with the World Health Organisation 'Patient Safety Challenge'.

**Method** Over three weeks the number of prescription chart errors were recorded, which included errors on personal details, allergies and antibiotic prescribing. Vancomycin and gentamicin are the most common antibiotics given on dialysis in NHS Tayside for line sepsis. Our proposed method of change introduced vancomycin and gentamicin stickers for the ward prescription chart, highlighting antibiotics given on dialysis. Medical staff were informed to utilise them in a departmental meeting. Thereafter, the prescription charts were re-audited over three weeks.

**Results** 86% of drug charts contained errors in week one. In weeks two and three, 100% and 50% of charts had discrepancies respectively. After the implementation, week one showed no errors on the drug charts. In weeks two and three, 20% and 60% of the charts showed mistakes respectively. There was a 66% overall decrease in drug chart errors. Nevertheless, week three showed an increase errors on charts.

**Conclusion** Although initial improvement was seen, the project 'fizzled' to an end as the junior doctors rotated. Due to the nature of four month rotations, it is difficult for positive change to be sustained. We consider this project highlights the