

from 2018 will not have experienced a system prior to the implementation of the 2016 JDC and ER.

Foundation doctors filled out a survey measuring potential barriers to ER and their confidence in ER. Teaching was delivered, explaining the process of ER with a focus on the identified barriers, followed by a repeat survey to assess for change.

81 trainees attended the teaching across two hospitals. 78 trainees filled out the pre-teaching survey, with 69 completing the post-teaching survey. 47.4% had submitted an ER by the mid-point of their 2nd/4th placement. 97.1% of trainees felt the teaching addressed some of the barriers to ER; such as 'explaining the process of ER' (50.7%), 'simplifying the process of ER' (49.3%), and 'recovery of log in details' (37.7%). 69.2% of trainees felt the major barrier to ER was 'too much hassle'. 26.9% reported that senior pressure was still a barrier to ER. An improvement in confidence levels was observed with initial confidence levels (1- unconfident, 10- confident) amongst respondents at a mean value of 5.49, following the teaching this improved to a mean of 7.03. 87% of doctors felt they were more likely to exception report following this presentation.

Trainees should be encouraged to exception report to identify areas of unsafe working, so that changes can be made to address this, and provide appropriate reimbursement for additional time spent at work. To facilitate this refresher sessions should be delivered to trainees, and the process of ER reviewed to ensure that it remains streamlined. Of note, there is still a perceived culture of senior discouragement with regards to ER. Further work will focus on understanding and addressing the barriers to ER amongst supervisors.

#### 10 IT MEETS LEADERSHIP IN ONLINE COVID WARD ROUND

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**Context and Aim** The target audience was the clinical team caring for patients suspected or confirmed of having COVID-19 at the Hatherton Centre, a secure psychiatric unit in Stafford, West Midlands. The COVID-19 pandemic presented multiple challenges: a novel disease alongside staff with little experience of managing acute medical needs for complex psychiatric patients, staff's risk of contracting or transmitting COVID, utilising staff working from home and decision making reflecting new research.

**Method** A twice daily virtual medical ward round was piloted using Microsoft Teams to provide medical leadership in the management of COVID-related patients for 5 separate clinical teams working in the unit. This also allowed staff working from home to be involved, information to be shared and communication improved with all involved. It further ensured that clinicians' time was spent more efficiently and minimised the risk of people moving between wards. Feedback was sought throughout and the ward round was adapted accordingly. Post-ward round feedback was sought by distributing a questionnaire to those directly involved. The questionnaire comprised nine questions comparing 'before' and 'after' the ward rounds were implemented.

**Results** Results showed a considerable improvement following the ward round. Staff felt more prepared, more confident, reassured with decision making, better informed and witnessed

improved team working and clear leadership. In addition staff spent less time on the ward, therefore reducing the risk of contracting/transmitting COVID. Problems, including poor internet connection, better communication to ward staff and discussion of un-related issues were resolved.

**Conclusions** This project shows how IT can be utilised to provide leadership and help manage new problems. It enabled staff working from home to support patients/colleagues, supported colleagues on the ward and contributed to staff well-being in a particularly challenging time.

## Developing Effective Leaders

### 11 JUNIOR DOCTORS AS SENIOR LEADERS – LESSONS LEARNT DURING COVID-19

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COVID-19 presented a huge unplanned pressure on health resources worldwide. Across the NHS, different approaches have been utilised to respond to the crisis. Leadership figures across services were faced with difficult decisions with potential scarcity of resources never before seen by NHS services, particularly in relation to critical-care bed capacity.

One of the key changes implemented in the acute Trust where I am based, was the placement of a junior doctor into Trust management and Leadership teams. Under direct supervision from the Trust director team I was released from the majority of my clinical responsibilities to provide leadership and oversight into decisions affecting junior doctors. This included leading junior doctor redeployment, inducting Foundation Induction Year 1 Doctors and designing and implementing a new out-of-hours service.

As a FY2 doctor, this provided a unique experience to integrate into senior management structures and lead several projects. Coming from a baseline of poor trainee feedback across several cohorts, it was recognised that this was an opportunity to instigate a culture shift across divisions.

This article will discuss the lessons learnt from this experience, highlighting areas for improvement, with the hope of providing a road-map for empowering junior doctors to take senior leadership roles in the future.

## Leading innovation and improvement in critical care

### 12 ISOLATED BUT NOT ALONE: CRITICAL CARE COMMUNICATION IN THE TIME OF COVID-19

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Many communication challenges became evident when the coronavirus pandemic led to the closure of Critical Care Units to visitors. Extra staff drafted in were unfamiliar with the ICU environment and needed to focus on direct patient care. The increased ICU footprint meant calls might be misdirected. Personal protective equipment (PPE) hampered hearing,