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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10.1136/leader-2020-FMLM.10

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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10.1136/leader-2020-FMLM.11

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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10.1136/leader-2020-FMLM.12

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,

speaking and phone use. Staff were unable to hold face-to-face family meetings and families were unable to be at the bedside which would, in normal times, enable them to be part of the patient's hospital journey. Inevitably, this all led to an increased volume of phone calls.

To try to solve some of these issues, it was decided that a dedicated team was needed to establish open lines of communication between patient, family and staff. A group of senior nurses from across the hospital were brought together to form the Critical Care Family Liaison Team (FLT).

FLT now give coordinated information and are the first point of contact for families. Interventions include using technology such as FaceTime and Zoom to allow 'virtual visiting', conference calling for family updates, bedside photographs, voice recordings sent in by families and music playlists.

The role for the FLT has evolved; the team was set up rapidly at the start of lockdown and members were in their new roles within a week. Daily verbal feedback was gathered from the medical team and interventions changed as necessary.

It is difficult to assess what the situation would have been without this innovation. Formal feedback was requested from all staff members working in Critical Care and from patients and their families. Qualitative and 5 point likert scale responses have been positive. Further data collection and feedback is ongoing to ensure the service continues to evolve as we move towards a new normal.

Improving in-patient experience

13 IMPROVING PATIENT COMMUNICATION WITH RELATIVES DURING THE COVID-19 LOCKDOWN

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10.1136/leader-2020-FMLM.13

Introduction The strict visiting rules imposed by hospitals during the COVID-19 lockdown left patients isolated and relatives distressed by the lack of contact. The aim of this quality improvement project was to improve patient communication with relatives, thereby enhancing their recovery and experience.

Method In-patients at St Mary's Hospital, London were asked if they were able to contact their loved ones and if there was appropriate technology available to facilitate this. Teaching was then delivered to healthcare professionals highlighting the importance of patient communication with friends and family, and posters were displayed to promote communication opportunities. Additional equipment was procured (through donations) to aid the process. A second data collection was conducted after 3 weeks.

Results The initial results revealed that 30% of patients were unable to communicate with their relatives, and only 16.6% were being offered the opportunity to contact them. Comments following the initial data collection included: 'I feel isolated because my family can't visit, and I don't have a mobile phone', and, 'the ward staff are too busy to call my family on the ward phone'. After the intervention 73.3% were offered the opportunity to contact relatives. There was a significant increase in use of the ward phone and video calls. This had an increase in both patient and family satisfaction; for example, a patient was able to ask a friend to deliver

their belongings, and a daughter of a patient with dementia was able to encourage him to eat via a video call.

Conclusion Proactive use of technologies in healthcare settings can improve patient care. Organising a teaching session, obtaining equipment, and encouraging healthcare workers to facilitate these important moments during an in-patient stay can have a dramatic impact on both patients' and their relatives' wellbeing.

A QIP on improving referrals of inpatient smokers with cardiovascular disease to the smoking free team

14 HELP US, HELP YOU QUIT SMOKING

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10.1136/leader-2020-FMLM.14

Introduction Blackpool tops for having the highest number of smokers and smoking related diseases in the whole of England. This QIP was carried out mainly in our Cardiology department with an aim to improve referrals of inpatient smokers to smoking free team thus paving way to have a team dedicated in the hospital. The annual cost to Blackpool's health service associated with smoking related illnesses are estimated to exceed 7 million/year with an additional £744,000 spent on treatment due to passive smoking. Although Blackpool Council has a smoking cessation team in the community, the lack of a smoking cessation team solely in the hospital led us to embark on this project.

Methods and Findings Data collected for 60 patients with cardiovascular diseases over a period of one month showed 75% of patients admitted under cardiology were either ACS or IHD. Among them, 85% were confirmed smokers. Due to poor documentation 94% of the patients were not referred to the smoking cessation team, that led to lack of advice and education to aid smoking cessation and thus affecting future follow up for 90% of the patients, who agreed to a long-term quitting plan.

Outcome Post education to healthcare professionals working on the wards, we saw drastic increase in the referrals sent to the smoke free team thus increasing the number of patients seen from 42% to 57%. Given the success of increased referrals from the cardiology department over one month, it provided good evidence and opportunity for the trust to form its own smoking team in the hospital.

Perioperative care

15 POST-OPERATIVE HYPOTENSION IN FRACTURED NECK OF FEMUR: THE ROLE OF THE HIGH DEPENDENCY UNIT

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10.1136/leader-2020-FMLM.15

Patients with a fractured NOF (Neck of Femur) present multiple challenges perioperatively. Since 2014, 11 major events