were analysed. Qualitative data was collected through a semi structured questionnaire and a Braun and Clarke (2006) method of thematic analysis was carried out.

Results The majority of patients found that TFU post cataract operation was an acceptable way to receive follow up. On average patients scored 4.94/5 on the likert scale for the simplicity and ease of use. Overarching themes that emerged were that TFU is more desirable as it saves time, travel and NHS resources. Overall, patients felt that if they had a post-operative complication they would have preferred to have seen a clinician in person. We found patients' views influenced by the COVID-19 pandemic meaning they saw additional benefits of telephone follow up compared to face-to-face review.

Conclusions The majority of patients felt that TFU after cataract surgery was an acceptable way to receive healthcare. This has implications for how follow up is provided after the most common operation in the UK and worldwide and opens the possibility of this being provided by an automated AI driven system in the future.

111 REDUCING INTRA-HOSPITAL TELEPHONE COMMUNICATION TIME USING APP TECHNOLOGY

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Background Lengthy switchboard waiting times result in delayed communication between healthcare professionals in a hospital. Wasted time impedes patient care, costs the Trust a substantial financial sum and impacts healthcare professional's morale. Aim: To reduce intra-hospital telecommunication time utilising the Induction phone application, an easy to use, regularly updated telephone directory. Methods: Initial audit: Five chosen specialities were contacted between 9–10 AM from the Emergency department for 2 consecutive weeks. The time taken to reach each speciality via switchboard was recorded. A survey seeking the number of calls made per day, the preferred method of contact and the feelings associated with telephone waiting times was sent to department doctors. PDSA cycle 1: One-month application advertisement and re-audit. PDSA2: Eye-catching tele-directory board with the most used extensions and bleeps displayed in the department. Satisfaction survey sent post PDSA2. Sustainability: New doctors were provided induction information. Results: Initial average waiting time via switchboard was 48 seconds. The average calls made per doctor each day was 12. This calculated to a total departmental loss of 20.16 hours per week waiting on the phone, equating an annual loss of £26, 208. PDSA1: Average waiting times reduced to 12 seconds utilising the application; saving an estimate ~£19,656 per annum. PDSA2: Instant availability of contact details on the display board further reduced waiting times to an average 6 seconds. 84% of doctors (n=16) disliked waiting more than 20 seconds, with associated feelings of frustration. 100% preferred the display board, then the use of the application before resorting to switchboard. 100% Sustainability was recorded one year later. Conclusion: The use of application technology reduces wasted time which hampers patient care; reduces Trust running costs; and improves health care professional's morale at work.

Understanding leadership through research

112 VILLAGES AGAINST CERVICAL CANCER: IMPROVING INDIA'S CERVICAL CANCER BURDEN BY EMPOWERING ASHA WORKERS

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Cervical cancer is the second leading cause of new cancer cases and cancer-related deaths among women in India, with an estimated 96,922 new cases and 60,078 deaths each year. (ICCR,2020) India bears over a tenth of the global burden of cancers, with preventable cancers like cervical, oral and breast cancer forming more than a third of the disease burden.(Ferlay, 2015).

Currently, early diagnosis via low cost screening methods play the biggest role in curbing the burden of disease. The screening methods employed are colposcopy examination and routine pap smears every 5 years. However, both screening methods, while effective in identifying the disease, require skilled clinicians and laboratories with appropriate set-ups.

One method to circumvent this problem of low screening rates is to train rural local women to carry out Visual Inspection of cervix with Acetic acid (VIA) as a primary method of screening, as it is a low cost method of screening which does not require much laboratory facilities.

The aim is to scale up the current rate of screening of cervical cancer and subsequently decrease the case fatality rate of cervical cancer in Indian villages. This will be done by training Female health care workers and rural health practitioners to carry out Visual inspection of the Cervix.

Overall, a lot is left to be done to help improve the burden of cancer in India, but the best route is to start with harmony of Public and private sector and prioritization of cancer care in India.

There is also a need to improve connectivity between rural and urban areas to facilitate shunting of cancer patients for tertiary care. Coordination with Ministries of urban development, transportation and infrastructure developers is necessary to ensure this.

Leadership lessons from across the world

113 TRAINING EMERGENCY MEDICAL STAFF TO APPROPRIATELY HANDLE PATIENTS WITH CHEST PAIN

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Coronary artery disease(CAD) is a common cause of morbidity and mortality in the world and many patients with CAD present with chest pain in an emergency setting as a first presentation. In emergency settings in India, the burden of diagnosis and treatment of patients with chest pain often falls on the emergency physician alone, who also has to deal with

other life threatening conditions at the same time. Thus, many acute presentations of chest pain can be missed or not receive the necessary treatment on time, in a busy, understaffed department. This significantly increases the mortality and future morbidity due to delays in the healthcare service provision to the patient.

One way to mitigate this is by training healthcare workers like Nurses, paramedics and other emergency healthcare staff to appropriately categorise a patient with chest pain as emergent and requiring ECG, so that the investigations needed can be carried out before the physician is able to clerk the patient.

This project was carried out in a tertiary care centre in Bangalore Urban, Karnataka India. First, the number of patients presenting with chest pain to the emergency department in a one-week setting were reviewed according to severity of symptoms using a 1–10 pain scale, other associated symptoms and presence of comorbidities or risk factors for Heart and lung diseases. The response time of the emergency staff to the patient from entry to the facility until appropriate management (shift to Intensive care unit, higher center referral, immediate prophylaxis, discharge) given was measured. A teaching session was conducted by emergency physicians involving all emergency staff following this. Using the data collected, a simple algorithm was devised to help staff make decisions regarding the treatment protocol. Training regarding reading an ECG, immediate prophylaxis for STEMI/NSTEMI patients and respiratory causes of chest pain was given to Nurses and senior Emergency non-medical staff.

Leading innovation and improvement

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AMBULATORY EMERGENCY CARE UNIT (AEC) IN PATIENTS' AND HEALTHCARE PROFESSIONALS' EYE

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Aim Assess the understanding of ambulatory emergency care between health care professionals and patients, in-line with ambulatory emergency care guide published by NHS Improvement June 2018. Also to highlight the teamwork, leadership and the bespoke improvements carried out to improve the service.

Methods A survey data collection with two separate questionnaires; one for patients with 4 questions, and another for healthcare professionals with 6 questions. Questionnaire forms were handed to patients who were waiting to be seen in Ambulatory Emergency Centre (AEC), also some healthcare professionals including GPs around Medway area, MedOCC, nursing staff and different grade doctors at Medway Hospital over the period of May 2019. Similar survey was carried out after 6 months of the improvement.

Results The initial survey showed misconception of the AEC services. Patients' survey showed 49% considered AEC as an outpatient clinic, 53% expected to stay less than one hour in AEC. Initial healthcare professionals' survey showed that 11% thought that patients with NEWS score 5 could be seen

in AEC. More than half (65%) were unaware of the AEC service. After the implementation of improvements and change the name of the service to Same Day Emergency Centre (SDEC), a second survey was carried out that showed improvement in patients' conception of SDEC services with only 1% considered SDEC as walk in clinic, 84% expected to stay less than 24 hours at SDEC. The second healthcare professionals' survey also showed great improvement with 92% of professionals knew the services provided by SDEC, and all healthcare professionals knew the referral criteria and the referral system.

Conclusions Team work is the key to make a change happens, and leadership is important factor for success. Response to issues regarding patients' safety is required from healthcare professionals to improve the service provided.

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COMMUNICATION, PROFESSIONAL DEVELOPEMENT, DATA DRIVEN DECISION MAKING

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10.1136/leader-2020-FMLM.115

Hand in hand with the COVID-19 pandemic, new processes were put in place to address such disease. The implementation of a structured and reliable process for swabbing of potential COVID-19 infected patients became critical. Nevertheless, this process did not come without problems in practice.

Around mid-March, it was noticed that over 10% of swab samples collected at Hillingdon Hospital were being rejected for analysis. A root-cause analysis through questionnaires and objective data sampling was conducted with support of internal stakeholders to explore the problem. Practical issues in sample handling linked to inadequate communication and training were identified as the main cause for sample rejection.

By the third week of March (i.e. one week in the project), an immediate approach was taken. With support from senior nursing staff, the team created an open space during hand-overs for the discussion of concerns and issues around sampling and technique. Ward specific figures and details were handed over to the ward sisters to inform each team.

During the second stage of interventions, in collaboration with several members of the multidisciplinary team, multiple scripts for an educational video were developed. Several video versions were released based on feedback and following updates from national guidelines. With support of Silver Command, the videos were distributed through the daily email communications and in the Trust's homepage. The actions implemented had an immediate effect in the overall sample rejection rate, reaching about 5% a month in the project, and dropping to less than 2% in later months.

The project improved communication within the teams and cooperation between the multidisciplinary team, highlighting the importance of continuous professional development. In moments of crisis, this union led to further support and reliability on leadership who was trying to promote safety among staff and patients during this difficult time.