All changes were discussed at MDTs. Adjustments and refinements were made as necessary due to the dynamic and evolving situation; changing guidance and staff availability due to illness, need for self-isolation and those shielding at home.

Patients were stratified according to their history and symptoms and their likely cancer risk.

Patients with high risk of cancer were offered face-to-face consultation, those at low risk were offered telephone consultation.

From 23rd March to 1st May 2020, we moved all possible patients to phone consultations. 299 new patients were vetted: 149 allocated phone appointment, 150 attended face-to-face clinics, of these 62 were diagnosed with breast cancer.

Initial phone contact appears safe with low risk patients. This will maximize available resources and reduce the pressures imposed by two week waiting list clinics on the breast services.

Covid-19 gave us the opportunity of demonstrating the strong, shared leadership existing in our group. The entire team proved able to adapt to different ways of working and embrace change, whilst continuing to innovate and thrive.

Breast surgery service changes during Covid 19 and adaptive leadership

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ADAPTIVE LEADERSHIP & MANAGING CHANGE IN BREAST CANCER SERVICES DURING THE COVID-19 PANDEMIC

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10.1136/leader-2020-FMLM.122

COVID-19 pandemic evolved rapidly and necessitated rapid, dynamic service reorganisation.

Utilisation and distribution of our individual team members' skillsets demonstrates our adaptive leadership across all aspects of the service.

We adhered to the Association of Breast Surgeons guidelines for breast cancer care to downsize activity and resources.

Objective of strategy was to maintain a consistent high standard of care, without compromising on NHS targets or cancer outcomes.

Face-to-face appointments (FA) were minimised to reduce the risk of COVID-19 infection.

A novel Vetting System stratified patients' symptom into High Risk of cancer (FA) or Low Risk (Telephone Consultation, TC).

Detailed patient spreadsheets were created, accessible on a shared drive as a real time dashboard - monitoring patient flow, recording triage decisions & outcomes.

We redesigned patient spaces with an 'in car' waiting room, single direction flow and patient-only admittance for clinic safety.

We suspended non-essential services: to preserve hospital resources; reducing non-essential attendances and allowing redeployment of staff to acute areas.

Data comparison over same period the previous year was used to gain an idea of the impact of activity changes and to anticipate additional workload post-lockdown.

March 23 to May 1st, 2020:

45 cancer surgery

296 new breast clinics

531 follow-ups (104 elected to postpone) 427 (331 TC, 96 FA)

26 breast screening

March 25 to May 3rd, 2019:

53 cancer surgery

507 new breast clinics

674 follow-ups

32 breast screening

Shortfall in new patients was related to reduced GP activity/patient reluctance to seek medical help.

Shortfall in follow ups due to postponements.

Subsequently clinical evaluation with patient experience questionnaires confirmed no cancer missed, no delays to treatment and no harm caused.

Adaptive leadership was essential in a time of unprecedented challenges.

Medical Education

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THE IMPACT OF COVID-19 PANDEMIC ON THE TRANSITION FROM STUDENT TO DOCTOR IN THE UNITED KINGDOM: IMPLEMENTATION OF TEACHING PROGRAMME

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10.1136/leader-2020-FMLM.123

Aims The aim was to evaluate the impact of the COVID-19 pandemic on final year medical students during a key period of transition into doctors. Cancellations of placements such as student assistantships severely disrupted this transition. Furthermore, a tailored teaching programme was implemented locally to aid the new doctors.

Methods A nationwide survey to graduating doctors and a focus group at The Hillingdon Hospital NHS Foundation Trust (THH) were conducted to identify concerns. We explored the students' impression of the disruptive effects of COVID-19, and the subsequent consequences this had on their preparedness and confidence. Subsequent analysis of the identified areas formed the basis of a teaching programme with 6 main domains: practical skills, attending arrest calls, prescribing independently, making referrals, prioritising jobs and on-call shifts.

Results 440 students across 32 UK medical schools responded to the survey. The impact of COVID-19 on OSCEs, written examinations, and student assistantships had significantly affected the students' perception of preparedness in starting as doctors (respectively $p=0.025$; 0.008 ; 0.0005). In contrast, when measuring confidence, only changes to student assistantships had a significant effect ($p=0.0005$). Locally, 90% ($n=9$) did not have a student assistantship whilst only 50% ($n=5$) had shadowed on call shifts throughout the entirety of medical school.

A pre- and post-teaching intervention questionnaire was performed. This showed an average increase of 26.4% in how participants scored their confidence and competencies post-intervention.

Conclusions The transition after undergraduate training is a steep learning curve. It is clear that student assistantships designed specifically to aid the transition should be protected