

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

122

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

Giuseppina Mondani, Mona Sulieman, Kali Potiszil, Imran Abbas, Polly King, Rachel English, Iain Brown, Philip Drew. *Breast Oncoplastic Surgery, Royal Cornwall Hospital, Truro*

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 re-deployment 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

123

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

Byung Choi*, Michel Alhilani, Lavandan Jegatheeswaran, Amal Minocha, Ernest Mutengesa. *The Hillingdon Hospitals NHS Foundation Trust, Uxbridge, UK*

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

and enhanced. Finally, in addition to the mandatory training all trainees receive, the taught material during induction should be tailored more towards new doctors' needs.

124 **JUNIOR DOCTORS AS LEADERS IN DEVELOPMENT AND LIVE MANAGEMENT OF A CONTINGENCY ROTA DURING THE COVID-19 PANDEMIC: OUR EXPERIENCE AT THE GENERAL SURGERY DEPARTMENT IN QUEEN ELIZABETH HOSPITAL, LONDON**

Michail Chatzikonstantinou, Cesar Brito-Ramirez, Paolo Sorelli. *SR in General and UGI Surgery. HE London, UK*

10.1136/leader-2020-FMLM.124

Clinical Fellow, Queen Elizabeth Hospital, London, UK

Consultant Colorectal Surgeon and Clinical Director, Queen Elizabeth Hospital, London, UK

The COVID-19 pandemic has affected millions of patients around the world. Hospital departments had to adapt their services and expand their bed capacity. Our aim was to lead a team that will create a contingency rota in order to anticipate possible COVID-19 related sickness and support front-line specialities, such as Acute Medicine and Intensive Care.

The team involved in the creation of this rota was led by one junior doctor from every grade. Data from the surgical take showed that the average number of daily surgical inpatients dropped from 47 in February, to 22 by the first week of April. This reduction, together with cancellation of elective operations, allowed us to create a contingency plan with a ward cover, an on-call and a stand-by team at all times. We managed to release doctors to support other departments, ensuring that surgical inpatients were receiving the pre-COVID-19 standards of care. We, also, created a 'buddy system', predicting possible COVID-19 sickness in the on-call or the ward-cover team. On this contingency rota, there was a ward cover team with one SHO, three FY1s and two registrars, including the team for ITU support and a 'standby' ward-cover team. Two of the FY1 doctors were redeployed to reinforce Acute Medicine. There was constant feedback via a 'WhatsApp' group from the on-call and the ward-cover team to recruit help from the standby team

All doctors who were part of this rota were invited to provide feedback via a satisfaction survey. Out of 13 responses, 61.54% replied that they were satisfied or very satisfied with the contingency rota, and 76.92% replied that the rota was fair to very fair. The rota was designed by Junior doctors proving that well-thought planning measures can make all the difference when facing extremely difficult and unprecedented situations like the COVID-19 pandemic.

Quality improvement

125 **IMPROVING FLUID PRESCRIPTIONS FOR INPATIENT SURGICAL INPATIENTS WITH DIABETES MELLITUS**

Piriyanga Kesavan*, Alexander Light, Oliver Bloom. *Bedford Hospital, Bedfordshire Hospitals NHS Foundation Trust, Bedford, UK*

10.1136/leader-2020-FMLM.125

Aims Surgical inpatients with diabetes mellitus are common. We aimed to assess the diabetes management of diabetic adult surgical inpatients. This includes reviewing appropriate medication adjustment with altered eating statuses; fluids prescribed alongside a variable rate intravenous insulin infusion (VRIII); numbers of hypo- and hyper-glycaemic events in those on diabetic treatment and appropriate hypoglycaemia management options prescribed.

Methods We audited current performance against national guidelines from the Joint British Diabetes Societies Inpatient Care Group. A prospective snapshot audit was conducted on surgical patients with diabetes mellitus on 3 surgical wards. Data, including diabetic status, eating status, prescriptions and hypo- and hyper-glycaemic events, were collated by reviewing patient notes, feeding instructions and prescription charts. The results were presented at the surgical governance meeting, including a short teaching session, following which a prospective re-audit was conducted.

Results 65 patients were included in the first cycle and 34 in the second. The percentage of patients on gliclazide with a bedtime snack prescribed increased significantly from 28.6% to 81.8% ($p < 0.005$). The percentage of patients with hypoglycaemic and hyperglycaemic events decreased but there was no improvement in the VRIII fluid and PRN hypoglycaemia prescriptions.

Conclusions Robust prescription of diabetic medications and fluids is essential for positive outcomes. The significant increase in bedtime snack prescribing for patients on gliclazide was notable progress. However, there is still more to be improved, with the need for greater awareness of the appropriate VRIII fluid prescription and use of PRN hypoglycaemia management protocol. Continual assessment and improvement of diabetic management is recommended to ensure high quality and cost-effective care.

Understanding leadership through research

126 **ARE WE GOING IN THE SAME DIRECTION: DO STAFF PERCEPTIONS OF THEIR OWN AND ORGANISATIONAL GOALS ALIGN?**

^{1,2}Stuart Bullock, ¹Chris Turner, ²Anne Slowther. ¹University Hospitals Coventry and Warwickshire, UK; ²Warwick Medical School, UK

10.1136/leader-2020-FMLM.126

Background When we consider what the right thing to do is, we call upon our own morals, professional guidelines, the law and other perspectives. We often combine these with our perceptions of the desires of those in authority. This work aimed to unpack staff perceptions of organisational drivers and gain an understanding of how and where we strike the balance between these multiple (and sometimes conflicting) perspectives.

Method 'Sheila is in the Emergency Department (ED) waiting to be admitted to a bed with a higher level of monitoring. She is about to breach the 12-hour NHS target and a non-monitored ward bed has become available. You must decide whether or not she can be admitted.' 112 healthcare professionals were asked how they would respond to this scenario.