Breast surgery service changes during Covid 19 and adaptive leadership

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.

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:

- 149 allocated phone appointment
- 150 attended face-to-face clinics, of these 62 were diagnosed with breast cancer
- 299 new patients were vetted: 149 allocated phone appointment, 150 attended face-to-face clinics, of these 62 were diagnosed with breast cancer
- Shortfall in new patients was related to reduced GP activity/patient reluctance to seek medical help.

Adaptive leadership was essential in a time of unprecedented challenges.

Medical Education

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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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.

**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

**Aims** Clinical leaders are pivotal in driving change and maintaining patient safety. To explore understanding of organisational goals, we asked whether staff perceived their own and organisational goals align.

**Methods** We conducted a cross-sectional survey among hospital staff. A questionnaire was sent to hospital employees. The survey comprised of questions on organisational goals, staff perceptions of own and organisational goals and organisational perceptions.

**Results** Analyzing the survey responses, we found that a significant number of staff members perceived the organisational goals to be at odds with their personal goals. This suggests a gap in understanding and alignment of personal and organisational goals.

**Conclusions** Understanding and alignment of organisational goals are crucial for effective leadership. Investment in staff training and communication strategies can help bridge this gap and promote a unified approach towards organisational success.

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**Abstracts**