honest and collaborative conversation. Student feedback emphasised the value of near-peer observation in encouraging information sharing with the group and discouraging relapse into counter-productive discussion and blaming. Following the course, students also reported using increased and broader opportunities for reflection and this was unrelated to the outcome of the situation.

These findings show students are an untapped resource for developing better, sustainable and more accessible reflective practice in medical education. It suggests the value of near-peers as role models to favourably cast the active pursuit of reflection, thereby increasing student internalisation of group reflection. Student-led reflective groups may address important gaps in the development of leadership skills in medical education. These skills have utmost relevance in training students to become part of the clinical workforce and improving patient safety.

Leadership opportunities for Junior Doctors

132 COVID AS A DRIVER OF CHANGE: LEADERSHIP OPPORTUNITIES TO IMPLEMENT NOVEL WAYS OF WORKING IN THE SURGICAL ASSESSMENT UNIT OF A DISTRICT GENERAL HOSPITAL

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10.1136/leader-2020-FMLM.132

Introduction Covid restrictions provided opportunities for novel approaches to patient assessment in the right place at the right time, whilst minimising unnecessary footfall in the Surgical Assessment Unit (SAU) of a UK District General Hospital. Prior to the pandemic, referrals were taken by Nurse Coordinators. Increasing call volumes put pressure on the department & disrupted clinical duties. Referrers often expressed difficulties in contacting SAU. 'Hot Clinics' (HC) reviewed patients attending the Emergency Department (ED) who did not require admission. Shielding Registrars led an innovative approach to triage SAU referral calls from General Practitioners (GP) & Nurse Practitioners (NP).

Aims To give Registrars an opportunity to innovate & lead service development through a novel way of working to triage SAU telephone referrals.

Methods Referral calls were diverted for triage by the hospital switchboard. Three outcomes were offered: Clinical advice, HC appointment or SAU review. Prospective referral data (15/6–31/7/2020) & retrospective non-triage data (15/6–1/7/2019) were gathered. Triage effects were measured by outcome comparison with non-triage data. Questionnaires were emailed to stakeholders.

Results From 15/6–1/7/2019, 56% of patients reviewed in SAU were sent home & 44% admitted, compared to 23.6% & 28.1% of referrals during the 2020 study period. Furthermore, 28.4% of admissions were avoided by triage. Only 3.1% of patients triaged presented to ED within 7 days. Triage reduced disparity in admission rates for GP & NP referrals (53.6% & 16.2% in 2019, compared to 29.1% & 26% in 2020). HC availability was limited. In view of reduced admissions, expanding this may prove cost neutral. Triage was

popular with stakeholders. Data will inform the Integrated Front Door project, to shape future development of Emergency Care. Conclusions: Traditional ways of working should be challenged. Novel approaches can be cost effective & positively impact patient care.

Developing effective leaders

133 EMPOWERING JUNIOR LEADERS DURING COVID-19: REFLECTIONS FROM A TEAM AT NORTH MIDDLESEX UNIVERSITY HOSPITAL

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Introduction North Middlesex University Hospital (NNUH) was one of the first hospitals affected by COVID-19, and one of the most pressured trusts dealing with the crisis in the UK. We describe a junior led initiative to manage the rapidly evolving situation and how lessons learnt from this experience can inform preparation for future events.

Methods In response to escalating issues on the ground, junior doctor representatives formed the Junior COVID-19 Working Group (JCWG) and worked alongside senior leadership to address front line challenges during the peak, as well as designing and implementing a trust-wide workforce restructuring project and an emergency rota.

Results With support from senior leadership, the JCWG was able to influence higher decision making and achieve numerous important interventions. Junior led rota design and workforce restructuring resulted in favourable outcomes for doctors' morale and perceptions of patient safety.

Discussion In the context of a novel crisis, junior leadership and engagement with higher management is essential in understanding and managing rapidly evolving situations on the front line. Our model highlights that in planning for future similar events, trusts should seek to champion junior led change via similar models, as well as invest in nurturing and training junior leaders.

Systems building during a pandemic

134 STAYING AHEAD OF THE CURVE – LESSONS IN COVID-19 PANDEMIC PREPAREDNESS FROM GIBRALTAR

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Gibraltar is a British Overseas Territory and has had a formal association with Great Britain since the Treaty of Utrecht in 1713. It has a population of around thirty-three thousand and shares a land border with Spain.

The first reported case of Covid-19 in Gibraltar was reported on the 4th March 2020 from a Gibraltarian

returning from Northern Italy. Early modelling completed by the Department of Public Health in March 2020 estimated the potential for five hundred Covid-19 related hospital admissions. St. Bernard's Hospital is the only hospital in Gibraltar and has a capacity of around one hundred and fifty beds.

The key issues identified early on were identifying a venue of sufficient capacity to create a Covid-19 field hospital, oxygen requirements and the actual building of the facility. A recently completed sports facility was identified as being available which had sufficient capacity to provide spaces for three hundred beds.

The major challenge was ensuring adequate oxygen delivery to the field hospital. As it was in a remote location, oxygen had to be sourced independently of the main hospital. An operational decision was made to only admit patients who required 5L/min oxygen or less. A contingency plan was made to ensure oxygen cylinders could be charged within Gibraltar at two units: a newly commissioned oxygen plant and the local hyperbaric unit. The field hospital was operational by the time of the expected surge in Covid-19 cases.

An important lesson is that each field hospital will have differing specialist needs but have a backbone of common requirements. New hospitals will need staff, equipment and a physical space. However, during the Covid-19 pandemic an important issue that was flagged up early was the requirement for substantial amounts of oxygen. This helped to guide our team to build a specific hospital for a specific situation.

Leadership and Management

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LEADERSHIP DURING THE COVID-19 CRISIS: HOW DID WE DO AND HOW CAN WE DO BETTER?

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Background The COVID-19 pandemic posed unique challenges to healthcare workers, who were required to adapt to a changing environment. This crisis put the spotlight on leadership qualities to provide safe, high-quality care. Furthermore, the NHS adapted from a divisional to 'command and control' based leadership that risked staff disengagement and exclusion. **Aim** To understand how leadership and management across three teaching hospitals in London were handled during the pandemic, and how lessons learnt can be applied to improve future healthcare leadership.

Methods A survey was sent to all anaesthetic trainees across three teaching hospitals in London. This contained 10 questions concerning the quality of leadership and care observed during the pandemic.

Results 68% of trainees felt more valued during the pandemic. 63% felt more listened to and better able to express concerns. 50% felt less included in decisions made. Only 23% thought NHS England and 14% thought Public Health England exhibited good leadership and communication on how to prepare

for and manage the crisis. Locally, 91% reported good leadership within their teams, and 91% agreed that patient care was sufficiently prioritised. Leadership qualities identified during the pandemic included compassion (reported by 86%), difficult decision making (reported by 82%) and staff engagement (reported by 68%).

Conclusions The results suggest participants felt more valued and listened to than previously, and suggest compassionate leadership was exhibited on a local level. The pressure on leaders during the pandemic highlighted the need for developing leadership and management skills. However the majority of trainees (68%) are not considering a career in leadership and management. We suggest implementing the NHS Leadership Academy's Healthcare Leadership Model App into anaesthetic training as a platform to engage trainees in developing their leadership skills, and provide the NHS with future healthcare leaders.

Urology

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REVIEWING THE CHANGE IN MANAGEMENT OF EMERGENCY RENAL COLIC SERVICES AND SURGICAL INTERVENTION IMPACTED BY COVID-19

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10.1136/leader-2020-FMLM.136

Background and Aim COVID-19 has resulted in changes to how the healthcare system in the United Kingdom delivered its emergency care, including renal colic and its management. Our stone team amended its services in order to reduce stone related morbidity and preventable hospital admissions. We aim to review similar time periods in 2019 and 2020 to see how this has changed.

Methods A retrospective review of all presentations of acute renal colic with CT confirmed stones were carried out for the months of April to May, 2019 and 2020. Demographics, clinical features and stone characteristics and treatment were noted.

Results Seventy nine percent of the 38 patients who present in 2019 had ureteric stones, compared to 85% of the 40 patients in 2020. Distal stones made up 53% in 2019, compared to 56% in 2020. Less patients were noted to be febrile in 2020(13%vs35%).

There was an increase in conservative management in 2020 (25% vs 21%). Emergency treatment (stent/nephrostomy) with secondary intervention (Ureterorenoscopy(URS)/Percutaneous Nephrolithotomy (PCNL)) was markedly reduced in 2020 (12.5% vs 42%). More patients were also treated with primary interventions (URS/PCNL) within 48 hours (43% in 2020 vs 26%) and 7 days (13% vs 8%).

Conclusion More patients were treated with conservative treatments and early primary interventions. This was done in order to combat unnecessary hospital admissions and stays, as well as surgeries and anaesthesia, whilst minimising stone and stent complications. An improved adherence to GIRFT guideless was also noted, providing better patient care and outcome, whilst reducing unnecessary procedures.