Collaborative learning between GPs, fledgling MDTs, and across the primary-secondary care interface has united colleagues around a shared purpose, starting solution-focused conversations.

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OUTCOMES OF THE ELECTRONIC MEDICAL TAKE LIST – IMPROVING STAFF EXPERIENCE, PATIENT SAFETY AND ROSTERING

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10.1136/leader-2020-FMLM.161

Aims and Methods The ‘medical take’ is a demanding process, whereby doctors review and manage acute admissions. We created a task force group and collaborated with Patienteer, a patient tracking software that can pull real-time patient information from our electronic medical record system Cerner, in order to improve this experience for our staff and ultimately improve patient care.

A bespoke electronic medical take list was which allowed us to overcome previously identified issues:

- Patient details were automatically added to the list (removing the potential for transcription errors)
- Multiple user access
- Live location
- Live NEWS2 scores

Thereafter, 6 months’ worth of data was analysed from February to September 2019.

Results Doctors were surveyed through an anonymised online questionnaire, with 27 respondents who had used both the old Excel list and the new Patienteer list. 89% found Patienteer to be improve efficiency. Two-thirds overall found it helped prioritise clinical need. 78% found patient details were captured more accurately with Patienteer. Accessibility was also thought to have improved, with 85% favouring Patienteer as being ‘easier’ or ‘much easier’ to access. 59% thought Patienteer had decreased their workload. 96% would overall, recommend the new Patienteer medical take list.

Through 6344 patient encounters, various outcomes were reviewed. There was a significant inverse correlation between NEWS2 scores and time taken for a medical doctor review: as NEWS2 score increased, patients were seen earlier. The time taken to be seen in minutes was expressed as $= -4.24621 \times \text{NEWS} + 133.031$, where NEWS is the NEWS2 score ($p=0.0002397$).

Conclusion The survey suggested the Patienteer medical take list had made the acute medical take experience more efficient and decreased the workload. There is also a suggestion that patient care is improved through the display of the NEWS2 score, allowing doctors to prioritise sicker patients earlier.

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OPTIMISING THE CLINICAL PATHWAY FOR PLACENTAL HISTOLOGY

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The Royal College of Pathologists (RCPATH) sets criteria for requesting placental histological examination which allows identification of pathological processes contributing to/causing an adverse obstetric outcome. Maternal intrapartum pyrexia is an essential criterion but is not part of the Guy's and St. Thomas' Trust (GSTT) guideline. There is no current baseline data on this at GSTT.

Aim To review current practice of requesting placental histology and amend trust guidelines to follow national recommendations.

Birth records from June 2019 were reviewed showing 8%(47/569) of deliveries were eligible for placental histology as per trust criteria but only 60%(28/47) were requested. A survey demonstrated 4% of staff were able to correctly identify all criteria for histology and there was confusion regarding formalin use. Neonatologists and pathologists were contacted to identify views on the usefulness of placental histology and the effect of adopting national criteria.

The pathologists confirmed all placentas should be sent in formalin unless specified by the obstetric team. The intrapartum infection guideline was amended to include requesting placental histology after approval by the intrapartum committee. The obstetric theatre posters were amended to include the extended criteria. A training presentation was emailed to all staff on the procedure for requesting placental histology.

The trust guidelines were successfully amended to include RCPATH criteria for placenta histology. Birth records from January 2020 identified 13%(63/487) of deliveries were eligible for placental histology, but only 56%(35/63) were requested.

The trust guideline for requesting placental histology now follows national recommendations. This may provide answers for adverse obstetric outcomes and reduce trust medicolegal costs. Unfortunately, no improvement in placental histology requests was demonstrated. Exploring potential barriers to improvement will be part of the next change cycle.

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QUALITY IMPROVEMENT PROJECT ON COMMUNITY INDUCTION FOR FOUNDATION YEAR 2 DOCTORS

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10.1136/leader-2020-FMLM.163

Foundation doctors regularly rotate through different specialties as part of their training. Inductions to these new placements can vary in delivery and effectiveness. High quality induction is a recommendation of the Academy of Medical Royal Colleges for safe trainee changeover.

Aim To improve the induction process for Foundation Year 2 doctors (FY2s) in community placements at Epsom and St Helier Trust.

A survey of 10 questions, devised from the British Medical Association guidance on adequate induction, was circulated to FY2 doctors (n=10) in community placements (GP and Psychiatry) between 4th August - 4th December 2019. Induction booklets individualised to each placement were created by

outgoing FY2s, then circulated to the incoming FY2 prior to rotation.

This aimed to enhance induction allowing for standardised peer to peer handover alongside local induction. Effectiveness of the intervention was assessed by repeating the initial survey during the second rotation December 2019-April 2020 (n=8).

Good engagement with the intervention resulted in creation of 8 individualised 'induction booklets' with mixed effectiveness. An improvement in preparedness was demonstrated for psychiatry placements but limited improvement in preparedness in GP placements. For psychiatry placements, improvements were demonstrated in trainees' awareness of supervisor contact details, timetables and annual leave arrangements. In all placements, gaps remained in confidence in IT and referral processes.

Induction booklets were effective in improving induction in community placements. However, its dependence on successful delivery of face to face local induction is significantly variable between placements. Limitations included small sample size, pause of rotation due to COVID-19 preventing a third cycle of audit and trainees engagement with induction booklets. Further improvements to include standardisation of local induction by developing a checklist of induction information.

Surgery

164 SURGICAL ASSESSMENT UNIT: LESSONS LEARNED FROM AN EMERGENCY SOLUTION TO STEM ED OVERCROWDING AMIDST COVID-19

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10.1136/leader-2020-FMLM.164

The nation-wide response to COVID-19 has impacted the structure of facilities and training since March 2020. Redeployment of trainees to areas of practice outwith their base specialties allowed for adequate staffing levels in high-risk areas. In Aberdeen Royal Infirmary, a Surgical Assessment Unit (SAU) and an Orthopaedic Assessment Unit (OAU) were established. The SAU engulfed Surgical Ambulatory Clinic (SAC) which was a unit formerly run from 9am-5pm Monday-Friday by a surgical consultant, assessing patients referred to the unit by General Practitioners.

Patients were triaged by ED and those without COVID-19 symptoms were referred to surgical specialty registrars before attending SAU. Data was collected retrospectively for attendances from 1st May- 31st May. Core trainees (CTs) from surgical specialties were redeployed from General Surgery (4), paediatric surgery (1), Urology (1), ENT (1), Plastics (2) to staff the Surgical Assessment Unit from 3rd May 2020.

Seven-hundred and ninety-seven (797) patients attended SAU, with an average of 25 patients daily. Admission or discharge outcomes are unknown for fifteen percent (118) of patients. 50% (395) of attendances were General Surgical patients, 19% neurosurgical and 11% urology. One-third (238) of patients attended SAU were admitted to hospital. Mondays and Tuesdays were the busiest days with 9am and 12pm being most common presentation time.

General Surgery accounted for the highest number of attendances, likely in part to its combination with SAC. High

neurosurgical attendances are a result of the new ED pathways referring all head injuries to specialty, including very minor ones.

165 SHARING LEADERSHIP: CURRENT ATTITUDES, BARRIERS AND NEEDS OF CLINICAL AND NON-CLINICAL MANAGERS IN UK'S INTEGRATED CARE SYSTEM

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10.1136/leader-2020-FMLM.165

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Background As systems become more complex, shared leadership (SL) has been suggested to have a dominant role in improving cross-functional working tailored to organisational needs. Little, however, is known about the benefits of SL in healthcare management, especially for UK's recently formed integrated care system (ICS). The aim of this study was to understand current attitudes, barriers and needs of clinical and non-clinical managers sharing leadership responsibilities in the ICS.

Method Twenty clinical and non-clinical leaders in fifteen organisations were interviewed to understand current cross-functional leadership collaborations, and the potential SL may have on the recently established ICS in the NHS. The data were transcribed and analysed thematically.

Results Findings showed perceptions and experiences of clinical and non-clinical healthcare management in relation to: (1) motivation to execute a leadership position, including the need to step up and a sense of duty; (2) attitudes towards interdisciplinary working, which is reflected in conflicts due to different values and expertise; (3) SL skills and behaviours, including the need for effective collaboration and communication by means of empathy, listening, and having a shared vision; and, (4) barriers to achieve SL in the ICS, such as bureaucracy, and a lack of time and support.

Conclusions SL may help improve current leadership cultures within the NHS; however, for SL to have a tangible impact, it needs to be delivered as part of leadership development for doctors in postgraduate training, and development programs for aspiring, emerging and established leaders, with clear lines of communication.

Acute Upper GI Bleed

166 ACUTE UPPER GI BLEED – OPTIMISING PATIENT CARE IN A DISTRICT GENERAL HOSPITAL

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10.1136/leader-2020-FMLM.166

Endoscopy is an essential tool in treating, diagnosing, and prognosticating patients with acute upper gastrointestinal bleeds (UGIB). NICE recommend all patients presenting with Acute UGIB should be risk stratified using the Glasgow Blatchford Score, must have an endoscopy within 24 hours of