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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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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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