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

admission if haemodynamically stable, and within 2 hours of resuscitation in patients with a severe AUGIB. The Joint Advisory Groups in GI endoscopy (JAGS) expects hospitals to offer endoscopy to least 75% of all patients presenting with AUGIB within 24 hours. They also recommend daily GI-bleed list for any hospital seeing more than 330 cases of AUGIB a year. Our audit was focused on analysing if the above recommendations are being met at our DGH hospital, and if changes suggested improve overall patient care.

A total of 341 referrals were collated from July 2019 - February 2020, from these the data for 262 endoscopies were retrieved and analysed.

The results showed on average, 63% of the endoscopies were done within 24 hrs overall. 100% of the referrals from the emergency department and the wards had a Glasgow-Blatchford Score completed pre-endoscopy. The most common symptom for referral was melaena. However in unstable patients, the commonest symptom was haematemesis.

In summary, we found out that our local DGH is short of the gold standard target of 75% endoscopy within 24 hrs of UGIB presentation. From the data gathered, this audit projects that in a 12-month period up to 450 UGIB endoscopies will be performed. As a result of this, we should be offering 7 days a week UGIB endoscopy service.

From this audit, we have been able to initiate the use of the Acute UGIB bundle in our emergency department. We have also presented the result at departmental meetings, to educate the junior doctors on the important of prompt referral to endoscopy as a means to ensure patients are getting their endoscopy within 24 hrs of presentation.

Leading innovation and improvement

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DEVELOPING FUTURE LIFESAVERS & BEYOND. IMPROVING CPR OUTREACH THROUGH MEDICAL STUDENTS

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10.1136/leader-2020-FMLM.167

Introduction Timely and effective Cardiopulmonary Resuscitation (CPR) can increase the survival rates by 3times. Bystander CPR rate in India is very dismal as 1.3%.¹ The present study aims to training all medical undergraduates in Basic Life support(BLS) for delivering effective CPR and Increasing` CPR outreach by training the community.

Methodology Students were divided into groups of 30, had three instructors, with a mannequin for every 3 students. Students were given video lectures, followed by hands-on training. Students were evaluated about confidence, likelihood of peer teaching, and implementation. The medical students were trained in first year, and again during Internship. A second-tier was proposed from May 2020,where trained undergraduates will be instructed to teach the CPR methods to a minimum of 5 people from the community using home-made mannequin. The program has been now temporarily halted due to pandemic.

Results Till date, 1950 undergraduates have been trained, and all 750 students in campus are BLS-CPR providers. The confidence to perform independent CPR after the

training was about 64.2%, with interneers being more confident (81.3%). Likelihood of implementing CPR was 40.9%, with those confident more likely to implement (54.3%). Likelihood of peer teaching was 22.9% overall, which was only 7% among those who were not confident. There was a significant difference among the above parameters between those confident and not confident after training ($p<0.001$). The program produces 150 new CPR providers per year, and second phase could add more than 3750 providers in the community, with 750 people being added each year.

Conclusion We proposed to empower future lifesavers who are young and enthusiastic about learning new skills and also to impart them to others there by increasing the number of first responders in the community.

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DEVELOPING FUTURE LIFESAVERS & BEYOND. IMPROVING CPR OUTREACH THROUGH MEDICAL STUDENTS

Ankathi Vyshnavi*, Varun Kumar Bandi, Satyanayana Murthy Pusuluri. *Dr.Pinnamaneni Siddhartha Institute of Medical Sciences and Research Foundation, Chinna Avutapalli, Vijayawada, Andhra Pradesh,India*

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