1 DOES YOUR PATIENT HAVE A TREATMENT ESCALATION PLAN? THINK, DISCUSS, DOCUMENT, VALIDATE

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Introduction Evidence suggests that healthcare professionals are poor at initiating discussions with patients about treatment escalation plans (TEP), despite most patients wishing to be involved in this. Patients are often subject to futile resuscitation attempts or distressing investigations and treatment while doctors on-call struggle with hurried decisions in acute settings.

Aim To improve documentation of treatment escalation plans for medical patients in the Acute Assessment Unit (AAU) at a district general hospital in London.

Methods Leadership, communication and awareness of staff was identified as primary drivers for this project. Utilising Quality Improvement (QI) methodology, we ran Plan-Do-Study-Act (PDSA) cycles for each of our interventions.

We utilised the local Morbidity and Mortality meetings to highlight the importance of advanced care planning. During Covid simulation sessions in the pandemic, we placed strong emphasis on discussing TEP for acute admissions. Morning board meetings served as a 'checkpoint' to identify patients without a TEP. We designed a TEP poster which was displayed in AAU and circulated on social media. Emails were sent to consultants and junior doctors regarding the importance of discussing TEP.

We identified improvement by calculating the percentage of AAU patients with a documented TEP which was done by analysing electronic records weekly. We also recorded any inappropriate cardiac arrest calls based on data provided by the resuscitation team.

Results This project ran across 49 weeks and included 500 inpatients. The initial documentation rate of TEP was 40% at the start of the project and had risen to 70% by the end of the project.

Conclusions Healthcare professionals should be well supported in decisions surrounding appropriate TEP as this is highly complex. Effective leadership in this regard is crucial to ensure delivery of high-quality patient care.

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2 'THE TALE OF TWO COUNTRIES' MY PERSONAL OBSERVATION STORIES ON HOW TWO COUNTRIES HANDLED THE WAKE OF PANDEMIC FOCUSING ON ETHNIC MINORITY PEOPLE

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Being present in two countries, Hong Kong and UK successively, when pandemic was just emerging, I was able to observe the wake of the pandemic and how it was handled especially by ethnic minority people in these two places. Hong Kong is a place, where wearing a mask in public area when a person is coughing or is sick is a normal sight to see. In terms of ethnic minority people, government tried to

reach out to them by distributing pamphlets and making public awareness videos in their own languages which were distributed through community NGO's, volunteers and leaders who all worked together and did their best from their own side by distributing masks, sanitizers together with organizing health awareness programs. This maybe largely because a. everyone in Hong Kong who were present during SARS virus time already knew the drill and knew what they had to do despite the uncertainty b. public are well disciplined in terms of health c. community leaders connect with people and act like channel for government awareness program. Remarkably the most pronounced thing that I observed in all this was, just before the pandemic period, Hong Kong was going through political upheavals but much to everyone's surprise, Hong Kong people managed to pick themselves together keeping their political differences aside and came together to fight the pandemic first. Wearing mask and social distancing was still an unfamiliar site when I had just arrived in London. Local NGO workers, volunteers in London were seen distributing masks, sanitizers while restaurant people were also seen distributing free foods to ethnic minority people. Not everyone understood or followed the social distancing rules because this was totally new concept to everyone including those around them. I felt that border control took more time in UK and people were indecisive about the government's health plan. Overall, experience and discipline does help in getting better result when it comes to public health.

3 'SAMPARK' (COMMUNICATION) TO CONNECT WITH PATIENT'S FAMILY IN COVID TIMES

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The Novel Coronavirus posed a unique type of challenge that the healthcare industry across the globe faced. Despite the prevalent infection control practices and infrastructural controls pre-existing in the healthcare organizations, the virus demanded further changes not only in the infrastructure, but also in our day to day practices and behavioral patterns. In the journey of coming forth and delivering best care, satisfaction of patient attendants was a challenge. Due to COVID appropriate regulations, family was not able to meet their Loved ones during admission in hospital.

Problem Identification The Hospital Management along with senior clinicians looked into the root cause through Ishikawa Analysis. How the Patient satisfaction score decreased to 92% in IPD. Ishikawa Analysis churned up the reason for dissatisfaction. During difficult COVID times, families were already under lot of psychological stress and not being able to meet their loved ones who were admitted in the hospital further adding to their dissatisfaction.

Intervention Step 1 -In View of addressing the communication Barrier, a dedicated family liaison team was established. Step 2-At the time of patient admission, one dedicated SPOC and contact details of designate attendant was taken from the patient family to share a real time feedback with them. Step 3- Any challenge what so ever was escalated to Medical Administration Team Step 4- 'Family Liaising Team' was in

touch with the on ground staff in COVID facility for any escalations and condition of the patient. Step 5 : Particular time slot was fixed for family briefing daily by the treating doctor.

Impact The impact has been multi-layered where certain changes did show an instant effect to its full magnitude. Patient Satisfaction Score increased from 92% to 96%. Appreciations from Patients and Family Members on different platforms like Google reviews ,twitter and software for patient satisfaction.

4 A COMPARATIVE ANALYSIS OF JUNIOR DOCTOR REDEPLOYMENT STRATEGIES DURING THE COVID-19 WAVES 2020–2021 – RCP CHIEF REGISTRARS EXPERIENCE

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Aim Large scale workforce redeployment was common during the Covid-19 pandemic, with junior doctors significantly affected. Royal College of Physician Chief Registrars helped facilitate redeployment and were affected themselves. They were able to compare strategies and leadership approaches between waves and different trusts.

Method Chief Registrars discussed their experiences during online discussions, collecting quantitative and qualitative data on a shared online template, with their Trust's consent. Data collected included number and grade of junior doctors affected, leadership strategies and feedback.

Result Complete quantitative data for both waves were available from 4 trusts, and partial from 7 trusts. 8 District General and 6 Tertiary/Teaching hospitals were represented.

Mean length of redeployment in wave 1 was longer (10.4 weeks [range 6.5-20]), compared to 6.2 weeks [range 0–10], with more doctors redeployed (mean 167 [range 40-259] compared with 42 doctors [range 0-86], despite higher numbers of Covid inpatients during wave 2. 1 trust implemented changes to working patterns instead of staff redeployment. Higher proportions of Foundation Doctors were redeployed in wave 2 (42%) compared to wave 1 (30%), with Core and GP trainees relative sparing (26% vs 12%).

All trusts reported clinical representation in organising and communicating redeployment decisions, and all but one involved Chief Registrar. There was wide variation in stakeholder involvement, with no correlation to hospital size.

Junior doctors reported feeling valued with a sense of team during redeployment. Feedback reported from wave 2 was less positive; shorter redeployment, frequent work pattern changes, suboptimal communication and burnout.

Conclusion A more nuanced approach to redeployment was taken in 2021 compared to 2020. Clinical involvement in redeployment decisions, improving communication and collecting feedback of those involved, should be priorities during any future redeployment.

5 A FELLOWSHIP FOR THE FUTURE: ONE TRAINEE'S UNIQUE EXPERIENCE OF A LEADERSHIP AND TRANSFORMATION FELLOWSHIP ENCOMPASSING PRIVATE SECTOR AND NHS EXPERIENCE

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In order to better understand how to be an effective leader, in August 2019 I embarked on a Leadership and Transformation Fellowship. It comprised of a year long secondment to the management consultancy health team at Deloitte LLP, followed by nine months as an Anaesthetic Transformation Fellow at Croydon Health Services NHS Trust, (with changes to timings to accommodate the pandemic). I was especially interested to learn how management consultancy intersects with our own quality improvement endeavours as clinicians.

Management Consultancy

I gained skills working on a range of projects which included: the transformation strategy of two acute NHS hospital trusts; clinical workforce redesign and service options appraisal at an Arms' Length NHS body; and national pandemic support.

Anaesthetic Transformation Fellow

I led a multidisciplinary project to create a Surgical Enhanced Care Unit (SECU) which provides post operative care for high risk elective surgery in a Covid protected setting whilst our critical care was unavailable. In the last year SECU has safely treated 129 patient. I also engaged in hospital-wide and departmental projects.

Lessons Learnt

- Transformation in the NHS is possible; whilst the pandemic has been disruptive it has revealed opportunities for dynamic change by motivated leaders.

- Effective change is best achieved when stakeholders are involved in a collaborative fashion, improving the likelihood of a meaningful impact.

- Building relationships is key, and can be challenging for a rotating trainee.

This Fellowship provided me with a unique opportunity to encounter a comprehensive range of healthcare leadership, from private sector and central NHS bodies, to trainee led projects. The experience has been invaluable, and I would highly recommend supporting trainees in leadership, as the benefits to the NHS would be innumerable.

My Fellowship was funded by Health Education England, the Royal College of Anaesthetists and Deloitte LLP.

6 A QIP TO ADDRESS PATIENT-CENTRED CARE BY INCREASING THE DISTRIBUTION OF PATIENT INFORMATION LEAFLETS (PILS) BY 10%, AT THE POINT OF PATIENT DISCHARGE AT PILGRIM HOSPITAL ED, BY MARCH 2021

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10.1136/leader-2021-FMLM.6

Background Patients discharged from ED should be provided with verbal and written discharge advice (1, 2). Patients