tailored rehabilitation to a wide number of patients. Further work needs to be done to establish best methods for engaging older populations and specifically those not confident in use of technology.

Technologies such as this have the potential to support patients from hospital to home, lending themselves to integration into the plans for the Integrated Care System

31 HOW A JUNIOR DOCTOR BODY CAN HELP COMMUNICATION, AND IMPROVE MORALE IN A LARGE TEACHING HOSPITAL TRUST

Michael Ewens, Stuart Haines, Laura Brown, Louise Buchanan, Dipesh Odedra. *Leeds Teaching Hospitals NHS Trust*

10.1136/leader-2021-FMLM.31

Leeds Teaching Hospitals NHS Trust (LTHT) has one of the largest cohorts of Junior Doctors in England, employing approximately 1,000 at any one time. Rotations occur every 4-12 months, before Juniors move to neighbouring trusts for further training.

LTHT's Chief Registrar chairs the Junior Doctor Body (JDB), a group of Junior Doctors, that meet virtually, monthly, representing each Clinical Service Unit and grade of Junior (Foundation Year to Registrar). The aim of the JDB is to increase communication between LTHT's Executive Team and Junior Doctors, who quite often do not feel a sense of belonging with their employer due to the short nature of employment.

In 2020/21, the JDB increased from 12 members, to 32, through a targeted communications campaign by the Chief Registrar. The inclusion of our Professional Support Unit helped highlight health and wellbeing resources for Junior Doctors within LTHT. This safe space allowed discussion of issues important to Junior Doctors, including: adequate rest facilities during the COVID-19 pandemic, refreshments, annual leave and impact of COVID on training opportunities and progression.

Each month, JDB reps were able to highlight any issues within their department that were not solved locally. Opportunities were cascaded to help juniors continue to meet training needs, including: quality improvement training and participation in collaboratives, COVID-19 vaccination research, and the chance to create educational resources in the correct use of personal protective equipment.

Executive Team members delivered talks on inclusion and diversity, patient safety and their career journeys; keen to ask for feedback to further make LTHT the very best place to train. Issues were able to be solved immediately within JDB meetings, helping Junior Doctors feel appreciated and respected; boosting morale during what has been a difficult year. We encourage all trusts to replicate the JDB model to boost morale nationally.

32 IMPLEMENTATION OF AN ONLINE MICROBIOLOGY REFERRAL PATHWAY IN A HOSPITAL TRUST – A QUALITY IMPROVEMENT REPORT

¹Kim Pramanik*, ²Sandra Long. ¹University Hospitals Leicester, Infirmary Square, Leicester, UK, LE1 5WW; ²Royal Blackburn Hospital, Haslingden Road, Blackburn, UK, BB2 3HH

10.1136/leader-2021-FMLM.32

Aims Appropriate diagnostic and antimicrobial stewardship relies on national and local data on antimicrobial resistance patterns unique to every region. Adaptive problems such as variability in the quality of information provided for antimicrobial guidance, inefficiency of a phoned referral system and reduced compliance with Royal College of Pathologists key performance indicator 6.3 of response to urgent referrals within one hour mandated a microbiologist-led change of referral method and content to improve assessment and management of a suspected infectious disease.

Methods A measurement plan comprising parameters quantifying the problems associated with phoned referrals was used over two plan do study act (PDSA) cycles. Approximately 25 patients were sampled randomly for urgent and non-urgent referrals during 2020 and 2021 using online consultation records. Interventions for this project were an online non-urgent referral pathway using existing trust-approved software rolled out for over four million patients, and online communications disseminated trust-wide to all clinicians for awareness and engagement. Feedback was sought in a third PDSA cycle using a survey via trust email, enabling sampling of clinician impressions.

Results Compliance improved in all parameters, repeat calls were prevented on re-assessment, and non-urgent referral information quality increased to 100% from 24%. Survey results (n=19) revealed that 89% preferred the online referral method, though increased awareness of the pathway was needed.

Conclusions Continued use would improve efficiency and transparency of communication, documentation and enable data collection for governance. Implementation of further PDSA cycles could promote sustainability and eventually reduce the risk of antimicrobial resistance. Future plans are in place to expand the clinician base to general practitioners within the region.

*Presenter

33 IMPLEMENTING NEW TECHNOLOGY IN THE OUTPATIENT SETTING: CHALLENGES AND OUTCOMES IN BLADDER DIAGNOSTIC ENDOSCOPY

¹Lara Ratcliffe, ²Brian Birch. ¹University of Southampton, School of Medicine, Southampton, UK; ²University Hospital Southampton, Southampton, UK

10.1136/leader-2021-FMLM.33

Aims To implement the use of an endosheath-covered cystoscope - a disposable sheath that fits over the cystoscope

Perform a service evaluation of performance of the new sheathed scope

To maintain safety and efficiency in the department

Become a leading centre for improvements in flexible cystoscopy techniques

Methods Participants undergoing flexible cystoscopy at Lymington hospital, UK between January 2018 to April 2020 participated in this service implementation of endosheath covered flexible cystoscopy. This received high levels of staff and participant engagement, quickly becoming part of the unit culture.

Participants completed 2 surveys, the first immediately post procedure; discomfort was rated on a 10 point visual analogue scale (1=no discomfort, 10=extreme discomfort). The second survey completed ~2-4 weeks later, development of

subsequent urinary tract infection (UTI) (patient self-report, GP records or antibiotic prescription).

Results Management approved the study and received strong support from both staff and participants showing high levels of altruism. This was due to high levels of engagement, communication and a clear plan as to what was being done and why, how this was to be achieved and how success would be measured. Additionally, staff felt the sheathed cystoscope handled well.

Overall, 1091 endosheathed flexible cystoscopies were analysed. It was a very well tolerated procedure with 33.2% procedures causing no discomfort, 48.2% mild and only 3.1% severe discomfort.

The UTI rate was 13.3% and impressively there were no reports of urosepsis.

Conclusions This safe, well tolerated procedure provides both cost and time savings to the healthcare provider. This study paves the way for developments in endoscopic imaging techniques and can be used as a leading example for other hospitals to implement the new techniques. This is also translatable to other units performing diagnostic telescopic evaluations in other parts of the body (e.g. bronchoscopy).

34 IMPROVING PHYSICAL HEALTHCARE FOR INPATIENTS ON A PSYCHIATRIC UNIT

¹Emma Watura*, ²David Denton. ¹University Hospitals Sussex NHS Foundation Trust, UK. Lewisham and Greenwich NHS Foundation Trust, UK; ²Sussex Partnership Foundation Trust, UK. Oxleas NHS Foundation Trust, UK

10.1136/leader-2021-FMLM.34

Background Good quality physical healthcare provision for patients with a serious mental illness can be challenging. Healthcare staff may feel they lack the knowledge and support to manage their patients' physical healthcare needs. Patients, therefore, may receive reduced quality of care for their medical conditions whilst an inpatient on a psychiatric unit.

Aims To identify areas for improvement of physical healthcare provision for inpatients on a unit for patients with psychiatric disorders.

Method A closed-loop audit was conducted on an inpatient psychiatry unit in West Sussex, UK. Retrospective data was manually collected from patient information systems. All new admissions between 14th January – 15th May 2021 were included for the first audit cycle (21 patients). After educational intervention, a second audit cycle was completed including all new admissions between 23rd May – 23rd July 2021 (18 patients).

Results The first audit cycle showed that 86% of patients had a physical examination and 76% had a venous thromboembolism (VTE) assessment within 24 hours of admission. It took an average of 13 days for the admission blood tests to be taken and, on average, 19 days for completion of admission electrocardiogram (ECG). Five patients did not have an ECG throughout admission. A reason for this was documented for four of these patients.

Following educational intervention, the percentage of patients having a physical examination and VTE assessment within 24 hours of admission increased by 8% and 24% respectively. The average number of days for admission blood tests and ECG completion decreased by 12 days and 13 days, respectively.

Conclusion The improvements made during this audit process may hasten the detection and treatment of medical pathology. Overall, this improves patient care and aids avoidance of the complications of delayed diagnosis or treatment.

*Corresponding author and presenter.

35 INTEGRATED MEDICAL LEADERSHIP EXPERIENCE FOR JUNIOR DOCTORS

Nelomi Anandagoda*, Jennifer Tringham, Olushola Alonge. *Frimley Health NHS Foundation Trust, Portsmouth Road, Camberley, GU16 7UJ*

10.1136/leader-2021-FMLM.35

The surge in admissions during the COVID-19 pandemic necessitated implementation of an incident rota for >130 junior doctors (JD) including new/re-deployed doctors. Conscious of the risk of feeling underprepared, isolated or lost in a big re-shuffle, JD were allocated to 5 teams each with a varied skill mix. Five registrars and ten SHOs, were identified by senior clinical leaders as showing leadership potential and appointed as 'Team Leaders' (TL).

TL promoted psychological well-being, provided peer-support for their team and managed rotas to ensure safe staffing across 30 wards. The chief registrar met weekly with TL to support leadership challenges and maintain an oversight of the expanded multi-speciality workforce. Supporting new leaders to be accessible and creating a support network allowed a large-scale change in working patterns, whilst maintaining a localised, team-based feel.

Prior to nomination, 44.4% of TL had no leadership experience. Therefore, a self-assessment survey covering the five domains of the medical leadership framework (personal qualities, team working, managing services, improving services and setting direction) was carried out to assess the impact of this experience.

The majority of respondents felt that they had achieved leadership skills covering all five domains. 100% felt that their TL experience made them more likely to seek future leadership roles with 66.5% considering applying for a specific leadership training programme e.g. RCP Chief Registrar and Darzi Fellow programmes.

As a result of the positive impact of this unique leadership opportunity an allocated weekly session has been incorporated into IMT3 job plans, with the aim of continuing to support and empower junior doctors to pursue senior leadership roles. Equipping trainees with the requisite technical and leadership skills to directly influence change throughout their careers and develop into tomorrow's clinical leaders will undoubtedly improve patient outcomes.

36 INTRAOSSEOUS CONTRAST INJECTION SERVICE IN ABERDEEN ROYAL INFIRMARY

Yajur Narang*, Senthil Ragupathy. *Aberdeen Royal Infirmary, UK*

10.1136/leader-2021-FMLM.36

Background Establishing rapid intravenous (IV) access during initial resuscitation in trauma patients is vital for optimum quality CT scan examination. However, this can be challenging and at times futile. Reasons like severe haemorrhage, obesity,