Representatives and were asked to participate as panellists. The methodologies addressed and used throughout the event were problem-based learning, reflective practice, formative feedback, and self-directed learning. The event was online and organised by Honduran healthcare professionals in 7 different countries. The congress allowed a national reflection on the methods currently used to train Honduran healthcare professionals and how this impacts patient care. Furthermore, a national discussion between the different medical schools was achieved which can open an opportunity for them to work together to improve training at all levels in the future. A much-needed transition from a traditional teacher-centre approach to a student-centred approach was discussed. Ultimately, the second national training survey following the first survey conducted in 2019 to assess the short-term impact of our national intervention is programmed.

17 DEVELOPMENT OF AN INTRODUCTION TO LEADERSHIP FOR EMERGING AND ASPIRING DOCTORS (I LEAD) COURSE

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10.1136/leader-2021-FMLM.17

It is accepted that all medical trainees have a leadership role alongside their clinical duties and it is widely required that specialty trainees complete a leadership training course prior to CCT. However there is little training and guidance for more junior trainees, nor a structured pathway of leadership training that would enable trainees to make impactful contributions to their teams and to quality improvement throughout their training journey. Therefore Health Education England aimed to develop a leadership training programme that was accessible from foundation level onwards to inspire and engage trainees and provide a platform to more in-depth training to those with a specialist interest in clinical leadership. This work focusses on the development and delivery of the Introduction to Leadership for Emerging and Aspiring Doctors (I LEAD) course for trainees at Addenbrooke's Hospital.

Three learning pillars were identified of leading self, leading others/teams and leading for improvement. The themes of patient safety, innovation and resource utilisation were present across each of these pillars. We designed sessions to explore team working, psychological safety, culture & leadership, operational management, quality and service improvement.

Anonymised written feedback was collected from 100 participants. 88% found the study day useful and felt it would change their practice, 9% were neutral and 3% did not find it helpful.

It is our intention that the health care system will benefit in a number of ways. We would anticipate increased staff well-being and retention due to self-management strategies. Skills gained in managing others and the team will lead to more effective and efficient teams. Increased understanding will lead to increased engagement with quality improvement projects and service development. Ultimately the identification and development of the clinical leaders of the future will continue to benefit all stakeholders moving forwards.

18 ENABLING FACTORS FOR QUALITY IMPROVEMENT ACTIVITY – RESULTS FROM A NATIONAL SURVEY

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10.1136/leader-2021-FMLM.18

Aims To identify enablers of success that can be used by junior doctors when undertaking Quality Improvement (QI) projects.

Methods In 2019/20 the Trainee Steering Group (TSG) of the Faculty of Medical Leadership and Management (FMLM) conducted a survey of FMLM members which explored aspects of leadership and management development.

Results 64 respondents answered questions related to QI.

For those involved in successful QI projects the key groups identified in supporting the projects were Other doctors (57%), Consultants (54%), Audit/QI departments (34%), medical students (24%) and nursing staff (24%).

Factors which were felt to have enabled a project's success were the involvement of senior figures (25%), importance of a team approach (22%), time to undertake QI, QI support (including QI departments, teaching and forums) (13%) and enthusiasm/perseverance (13%).

Ways in which respondents felt their employer could help make sustainable improvements included facilitating time to undertake QI activities (25%), supportive senior leadership and environments which support QI (23%) and mechanisms to 'handover' QI projects thereby overcoming the impact of short trainee rotations (14%).

Conclusions When junior doctors undertake QI projects their chance of success can be strengthened by working in a team which ideally includes a senior leader. They also benefit from engaging with their organisation's QI resources and support. Finding time to execute the project is essential and needs consideration and planning.

Organisations enable the success of junior doctor QI involvement by creating environments in which QI is celebrated, supported and visibly encouraged by senior leaders. Developing a process for 'handing over' projects is recommended. Facilitation of time to undertake QI remains a key enabler.

The TSG have produced 'Top Tips for QI', a document to share these key messages with junior doctors, enabling them to learn from the experience of their peers.

19 ESTABLISHMENT OF ACUTE RESPIRATORY HUB (ARH) SERVICE DURING COVID-19 PANDEMIC

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10.1136/leader-2021-FMLM.19

Background During the COVID-19 pandemic, it was necessary to rapidly reconfigure primary care to enable COVID-19 patients to be seen in dedicated respiratory hubs to avoid risk to existing primary care staff, avoid admissions and protect secondary care services. A rapid deployment of primary care respiratory services was implemented as a result.

Aims/Objectives To study the experience of rapid re-deployment of primary care services into dedicated respiratory hubs during the COVID-19 pandemic.

Methods The service model was rapidly implemented using successive PDSA cycles and NHS model for improvement methodology; undertaking rapid redeployment of resources to include clinicians and PPE to dedicated respiratory hubs. This enabled increasing numbers of COVID positive patients and those with respiratory infections to be streamed towards dedicated respiratory hubs. Using clinical SystmOne community modules, remote booking was enabled to allow practices to book directly to a respiratory triage gateway. Senior clinicians were able to triage patients virtually while selecting those requiring clinical face-to-face assessments. This maximised already meagre supplies of PPE within primary care and provided the most cost effective solution. Exposure of patients and staff within the community was also minimized.

Results The service was both clinically effective and highly valued by patients, staff and physicians in primary care. We were also able to study prescribing behaviour and delivered an admission avoidance service protecting secondary care from inappropriate demand induced by the COVID-19 pandemic.

Conclusions We believe our methodology of implementation has proven the worth of integrated GP clinical systems and whole system integration via triage pathways that controlled patient flows towards the most clinically appropriate services during COVID-19 pandemic protecting secondary care services from being overwhelmed.

20 ESTABLISHMENT OF TELEMEDICINE FOR COVID-19 AFFECTED PATIENTS AT HOME ISOLATION IN A SECONDARY CARE HOSPITAL IN THE CONTEXT OF COVID-19 PANDEMIC

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10.1136/leader-2021-FMLM.20

Aim Establishment of telemedicine for COVID-19 affected patients at home isolation in a secondary care hospital in the context of COVID-19 pandemic.

Methods While I was volunteering for the national telemedicine support for COVID-19 patients, a thoughtful implementation of the same in our hospital to help home isolated COVID-19 patients was made by our team. After seeking permission from the management, circulars were dispersed by means of hard copies and digital pamphlets to the employees' homes. We trained doctors in standard operating protocol, ethics and legalities of telemedicine and COVID-19 home isolation guidelines. Apart from these periodic meetings held to address the problems, regular feedback from doctors and the patients noted, COVID-19 case audits conducted, a nodal officer assigned for liaising between the hospital, patients and for primary contact tracing. All the tele-consulted patients information documented were updated to the local government bodies.

Results The whole process nurtured young leaders in the unprecedented times aiding the leadership to break barriers and adapt to function efficiently. Telemedicine transformed the patient-doctor relationship helping to build good rapport, became an efficient way of treatment and the patients accepted telemedicine as it was safe for their families.

Conclusion A leader's role in the healthcare system is to empower innovative solutions by fostering interaction and aiding quality patient care. We used the COVID-19 pandemic to

transform a secondary care hospital into a more resilient system. Telemedicine was a ray of hope for distorted patients, challenged the perception of the existing practicing methods and skills. Telemedicine made counselling easier and helped to save many lives.

21 EVALUATING COVID-19 SURGE ROTA MODELS AND INVESTIGATING THEIR IMPACTS

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10.1136/leader-2021-FMLM.21

Aims It is currently unclear which approach to staff management during Covid-19 disruption allows clinical practice optimization whilst ensuring junior doctor resilience. Our project aimed to provide an optimised surge rota at East Sussex Healthcare Trust during the second Covid-19 surge to improve workforce experience and to allow us to prepare for future surges while ensuring patient safety.

Methods A novel surge rota was developed alongside a diverse group of representatives with backgrounds in medical education, hospital management and general medicine. The new rota was more flexible and built on the regular 2016 Junior Doctor contract with the addition of supportive staffing and environmental changes. These included a variety of changes informed by the previous discussions regarding the rota used during the first surge. Improvement was measured during feedback sessions with individual doctors. Furthermore, qualitative and quantitative questionnaire data was gathered and analysed using descriptive statistics for presentation and summary.

Results Our results suggest the novel surge rota was an improvement upon other rotas used during the first Covid-19 surge. The main factors that affected this were: more senior and specialist support, timely consultant assessment of newly admitted patients, and extra locum cover. The novel rota facilitated more flexible workforce distribution, translating into improved overall junior doctor wellbeing throughout the surge.

Conclusions The identified rota tactics are recommended for future disruption and more can be understood on this topic. Open communication through hierarchies and disciplines is pertinent when synthesising diverse stakeholder opinions. A well-received surge rota is possible and rewarding, with improvements to be seen nationally. Moving forward, it is important to develop surge rota designs to improve resilience to chronic disruption, reduce burnout, and most importantly improve patient safety.

22 EVALUATION AND MODIFICATION OF MEDICAL HANDOVER USING TRAINEE FEEDBACK AND TECHNOLOGICAL ADVANCEMENTS

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10.1136/leader-2021-FMLM.22

This project involved trainees and consultants working together on this project to transform on-call medical