handovers at one London NHS site. The site composed 19 forensic secure psychiatric wards, an older adult psychiatric ward and the Home Treatment team.

Before the intervention, handovers were carried out via verbal communication between consecutive Core Trainees. A separate telephone handover took place between the Core Trainee, Speciality Registrar and Consultant on call. The primary driver of this project was the lack of quality communication at handovers. Our aim was to increase safety, efficacy, and accountability. Successful processes at other sites and trainee feedback was analysed. It was decided to implement an email handover system and to utilise MS teams for enhanced communication of verbal handovers.

One problem encountered was ensuring dissemination of the new handover protocols across all affected staff members. This problem was surmounted with regular communication of the changes.

Ongoing feedback showed approval ratings of over 83% amongst some trainees. Trainee feedback was used to continue to shape systems in place, to continue our PDSA cycle of change and improvement.

This solution illustrates how utilising simple technology can transform reliability and continuity of care. The project demonstrates the power of trainees to enact change using simple, practical solutions by using open dialogue and negotiation with the trust, which has increased trainee morale. In this way, a tailored solution specific to the needs of the medical staff was produced. The project also leaves a lasting legacy of introducing technology into the handover, which can continue to evolve as new technological advances arise.

23 EXTENSION OF A UNIVERSITY BASED PERIOPERATIVE MEDICINE PROGRAM TO A DISTANT RURAL HOSPITAL

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10.1136/leader-2021-FMLM.23

Leadership at Fairview Range Medical Center initiated the project by approaching leadership of the University of Minnesota.

Department of Anesthesiology at the University negotiated a contract to provide medical directorship of the operating room and medical directorship of perioperative medicine services. The current medical directors of both services at the University of Minnesota were appointed dual roles in each site.

Medical Directors have monthly visits via scheduled air service to meet administrative, surgical and medical leadership.

Development of a robust tele medicine program to provide preoperative, intraoperative and postoperative anesthesia care with video technology.

Collaboration between rural hospitals and academic medical centers should facilitate provision of the best possible evidence based perioperative care for the largest surgical population. We have demonstrated the ability to use multiple platforms synergistically to collaborate on all facets of perioperative care. The cooperative venture has been well received by all providers and has energized care in both hospitals. Similar collaborations could greatly improve care and value for the 20% of the population that receives care at rural hospitals. While telemedicine has been described to assist preoperative assessment, this to the best of our knowledge is one of the

only programs that offer real time intraoperative and postoperative anesthesia consultative management via tele medicine.

24 EYESTRIVE: A VIRTUAL OPHTHALMOLOGY TASTER PROGRAMME FOR FOUNDATION DOCTORS LOOKING FOR AN INSIGHT INTO A CAREER IN OPHTHALMOLOGY DURING THE SARS-COV-2 PANDEMIC

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10.1136/leader-2021-FMLM.24

Background The implementation of social distancing measures during the SARS-CoV-2 pandemic limited Ophthalmology departments in offering face-to-face taster days to foundation doctors to promote career development. Therefore, we developed an e-learning platform for junior doctors to gain an insight into Ophthalmology, while maintaining the same level of detail as face-to-face programmes.

Methods We explored the literature surrounding medical education adaptations to social distancing measures. A pre-programme survey was conducted investigating interest in a virtual Ophthalmology taster programme within the Yorkshire and Humber deanery. A positive response resulted in the development of 'Eyestrive' – a comprehensive e-learning platform (www.eyestrive.org.uk). It consisted of five pre-course modules, each led by a consultant ophthalmologist, followed by a full day virtual interactive workshop comprising of lectures and wet lab. The modules included:

1. Clinical Skills: resources on ophthalmic examinations with follow-on feedback.
2. Clinical Signs: photographs of ocular pathologies complemented by multiple choice questions.
3. Special Module: a) Teaching Others b) Audit/Quality Improvement c) Critical Appraisal
4. FRCOphth Part 1 Club: key topics of the exam taught by trainees.
5. Virtual Wet Lab: attendees practiced suturing and knot tying techniques under supervision.

Results Twenty-four junior doctors attending from UK, Ireland, and Malaysia completed the programme. Pre- and post-programme questionnaires showed increased confidence in critical appraisal and surgical skills, understanding of quality improvement principles, and the ability to assess the acute red eye.

Conclusion Eyestrive sets a blueprint for designing a virtual training programme. The pre-course modules followed by 'virtual workshop' can be applied to undergraduate and postgraduate medical teaching across various specialties. In the COVID era, this has been a timely contribution.

25 FIND A WAY OR MAKE ONE: A PROJECT TO IMPROVE THE HEALTH PLANNING PROCESS IN SRI LANKA

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10.1136/leader-2021-FMLM.25

Background National Planning Department is the central organization granting project approvals in the government sector in Sri Lanka. As a prerequisite for implement a project, an approval is mandatory. This entire process was paper-based and possessed several limitations resulting in stagnations and rejections. Four major gaps identified in the current process: insufficient knowledge and experience of the personnel in project formulation and submission, unavailability of guiding materials in native languages, absence of project appraisal mechanism and lack of feedbacks. To address these issues, a set of interventions designed and implemented.

Methods Project was carried out in three phases at the decentralized health management units in Northern Province of Sri Lanka.

Phase I, a preintervention arm involved evaluation of current proposal statuses.

Phase II consisted design and implementation of interventions. Upon identifying gaps, an online proposal feedback portal that used colour coding and provided real-time feedbacks was developed. Health planning unit staff were trained through workshops to develop project proposals and get feedbacks via an online portal. A project appraisal committee also formed and guiding documents translated into native languages. Phase II spanned across three months.

Phase III comprised of post-intervention result assessment.

Findings Post-interventional analysis indicates that all major gaps are bridged.

Evaluation of submitted and approved project proposals revealed a post-intervention approval rate of 60-100% as compared to pre-intervention which was 40-50%.

Post-intervention mechanisms were rated more favorably than pre-intervention, including convenience to obtain feedback (mean 2.0-4.29) and were statistically significant.

Impact This research project is bringing an impact on Health Care System by ensuring the timely implementation of the projects without delay. It prevents cost, quality and time overruns.

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HEALTH WORKFORCE AND HOSPITAL CAPACITY MANAGEMENT IN THE CONTEXT OF COVID-19 PANDEMIC RESPONSE

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10.1136/leader-2021-FMLM.26

Aims a) Health workforce and hospital capacity building in the covid-19 pandemic.

Challenges a) Lack of adequate staff capacity including ICU capable staff b) Need for real time re-designs of models for COVID-19 patients, without affecting essential services.

Intervention 1) Measures taken to improve staff levels:

Recruited and trained doctors and nurses from other specialties. Temporary re-deployment of clinicians of various specialties. New graduates were mentored and on-the-job training for generalist workers provided.

2) Measures taken to increase hospital capacity:

Reduced elective medical care Altered and re-purposed clinic and underused spaces for COVID-19 services. Home-based care for COVID-19 patients with mild or moderate symptoms.

3) Additional strategies :

Developed COVID-19 pandemic preparedness committee. Nodal officer nominated to liaise with government authorities. Rapid procurement of ventilators, oxygen concentrators and respirators for health care workers. Telemedicine platforms for clinical advice to patients.

Impact Expansion of staff and bed capacity, ensured that COVID-19 and non COVID-19 emergencies were treated adequately.

Conclusion Health care organizations will be challenged to adjust capacity, redesign care and redeploy staff in a pandemic. Building health workforce capacity, will support health systems in the immediate response and also form a foundation for global health security in future.

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HEALTHCARE IN THE TIME OF A PANDEMIC AND BEYOND: THE INNOVATIVE LARGE-SCALE AND INTEGRATED SAUDI NATIONAL HEALTH COMMAND CENTRE

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10.1136/leader-2021-FMLM.27

Background The increasing frequency of pandemics, and costs of healthcare services requires integrative, efficient and effective health systems.

Aim Describe the framework and distinctive outcomes of the Saudi National Health Command Centre (NHCC). **Method:** A review was performed to describe the system-based engineering approach utilised to design the Saudi NHCC. This smart centre creates a new model of care delivery which impacts clinical and operational indicators by adopting integrative and interdisciplinary methods to analyse, disseminate, manage, and measure outcomes.

Results The NHCC is structured into four main departments with data integration and real-time data visualisation to allow for rapid assessment of available resources. It's organised to support technical incubators and empower several initiative. This enhanced the proactive capacity management in the centre and collectively contributed to several favourable outcomes. These included rapidly deploying medical staff and mechanical ventilators during its response to coronavirus disease (COVID-19); bending the curve early of the first wave of COVID-19 resulting in a low mortality rate (<2%); and reducing ICU lengths of stay by 10%, average lead-time of the supply chain from 60 days to 25 days, and surgery waiting times. It also supported the increment bed capacity from 6,000 to 10,400, and maintaining the percentage of patients receiving care within 4 hours in emergency departments above 85%.

Conclusion The NHCC replaces the traditional reliance on the subjectivity of information-based processes with actionable data, which helps building fairer systems to tackle structural inequalities in healthcare access and outcomes, eliminating waste, and allocating resources more effectively and efficiently. Importantly, a command centre to healthcare design and delivery creates synergy between people, processes, and technology