5 Points were consistently highlighted in survey returns:

1. Information not covered in induction/factually inaccurate/omitted from guidelines.
2. Information originated from senior peers only.
3. Minimal role clarification.
4. Documents were complicated and very long.
5. Lack of or difficulty in access to shift documentation.

Intervention and results To intervene a presentation was created, known as 'The Idiots Guide to Foundation On-Calls' ('The Guide'). This covered all shift roles, bleeps, responsibilities, timings and handovers. It was delivered at induction, via email and available online.

Repeat survey results showed 89% of stakeholders surveyed found 'The Guide' very useful or quite useful, with average confidence score increasing from 2.1 (pre-intervention) to 3.4 (post-intervention). There was a reduction from 67% of poor results (scores of 1 or 2) to 30%, alongside an improvement from 17% of scores 4 or 5 to 40%.

Lessons learnt

1. Involving the key stakeholders in the development of information for the induction processes leads to much better satisfaction and outcomes.
2. Guidelines should be simple, accurate, easy to read, accessible, promoted by others and regularly updated and reviewed by stakeholders.

Quality improvement, leadership, management

25 JUNIOR DOCTOR CHANGEOVER: A COLLABORATIVE APPROACH TO IMPROVEMENT

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10.1136/leader-2018-FMLM.25

Background The South Eastern Health and Social Care Trust (SEHSCT) is one of 5 trusts in Northern Ireland. On changeover days (first Wednesdays of August and February) junior doctors are invited to signing on sessions organised by the Human Resources (HR) team to complete paperwork and receive identity badges. Changeover can be a busy time for junior doctors and the HR Team. Feedback from the August 2017 signing-on sessions indicated dissatisfaction with lengthy waiting time, badges not correctly activated and difficulty accessing clinical care areas.

Aim To improve the signing on process for junior doctors starting new training posts in the SEHSCT

Methods We organized joint meetings between junior doctors and the HR Team and employed PLAN-DO-STUDY-ACT cycles.

For the February 2018 changeover, we improved the practicalities of the signing on process for junior doctors. Improvements included:

- Advance Electronic Form and Photograph Submission
- Advance Identity Badge Preparation
- Venue Change to Reduce Queuing.

For the August 2018 changeover we organised a Welcome Evening for junior doctors. This event combined the signing-on process with leadership talks from the SEHSCT senior management team.

Results Focus group feedback was very positive and 32 doctors completed written questionnaires:

- 100% of doctors said they felt welcomed to the SEHSCT
- 91% of doctors would attend a welcome event in the future
- 97% of doctors rated the event as good/very good/excellent
- 100% of doctors rated the venue as good/very good/excellent
- 97% of doctors stated they better understood the management structure of SEHSCT.

Conclusions Improving the signing on process required collaboration between junior doctors and the HR team. There is a firm working relationship between both parties, based on mutual respect and appreciation for each other's perspectives. Doctors now start their experience at the SEHSCT feeling welcomed and valued.

Retention of the general practitioner workforce

26 WHAT ARE THE PERCEPTIONS OF FACTORS AFFECTING GP WORKFORCE RETENTION? A QUALITATIVE STUDY OF GPS IN THE WEST MIDLANDS

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Background GP retention is a serious issue. Despite recent increases in patient volume and demand, workforce numbers have failed to adapt. Between 2005 and 2014 the number of GPs leaving almost doubled, and nearly half of those intending to leave are under the age of 50; if uncorrected, this poses a sustainability issue for the NHS.

Aims The aim of this study was to explore the perceptions and views of GPs regarding GP workforce retention.

Methods Six GPs were sampled by convenience sampling, and underwent semi structured telephone interviews in March 2018 of up to an hour. Interviews were transcribed by the researcher and analysed thematically using the six step approach by Braun and Clarke.

Findings There were five themes and ten subthemes. Themes were: increasing and changing patient expectations, consultation changes, system pressures, lack of leadership and culture. The ten subthemes were lack of patient education, increased patient consumerism, time pressures, restricted practice, breakdown in doctor patient relationship, non-primary care pressures, administrative pressures, government interference, organisational culture and workforce culture change.

Conclusion A breakdown in doctor patient relationship, increased patient consumerism and limited resources provided by the government, coupled with the less vocational workforce culture of newer GPs, have all contributed to a

desire to leave practice. A lack of leadership opportunities for GPs was found to negatively affect job satisfaction due to reduced autonomy and opportunities to impact upon decision making. Formal leadership training could be developed, which has been shown to increase engagement with leadership in clinical commissioning groups and reduce the conflict of values that a hybrid clinical-leadership role brings. Other ways towards increasing leadership without detracting from clinical work would be to create leadership fellow positions and advisory posts, to ease GPs into these roles.

Electroconvulsive therapy, psychiatry, special care dentistry

27 DENTAL RISK ASSESSMENT AND MANAGEMENT IN ELECTROCONVULSIVE THERAPY (ECT)

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Northamptonshire Healthcare NHS Foundation Trust has recently developed a new dental risk assessment toolkit for patients undergoing electroconvulsive therapy (ECT).

The project has been led by an Integrated Clinical Fellow working between the specialist dental service and psychiatry. This fellowship funded by Health Education England was delivered in collaboration with the trust's Medical Director and Deputy Medical Director.

The project aims to optimise patient safety as well as address the gaps in knowledge held by the ECT team through current guidance provided by NICE and The Royal College of Psychiatrists.

A focus group consisting of anaesthetists working in ECT have raised concerns regarding their confidence and ability to manage dental risk in the context of modern developments including legal issues of risk management and consent, patient attitude to dental health and technological advances in dentistry. This has indicated a need for tools to support best practice.

A questionnaire was designed and distributed at a national ECT conference. This provided information on current practice across the country and indicated inconsistencies in practice.

An interactive e-learning workbook was developed using educational theory and learner activity design. Doctors and nurses completing dental assessments contributed to the design, identifying the aims and intended learning objectives. This is the first training resource of its nature to be designed and implemented within the field of ECT.

Simple and effective training has empowered staff to confidently complete an appropriate dental assessment. Clinical implications have been reported by anaesthetists with improvements in management techniques. The team has recognised that dental assessment should be a shared responsibility.

The project has led to the proposal of a national minimum standard for dental assessment criteria to better identify and manage patients at risk of dental and oral soft tissue trauma.

Developing effective leaders

28 WHAT I LEARNED FROM LESSONS LEARNT: A JUNIOR DOCTOR'S PERSPECTIVE AS A LEADER IN PATIENT SAFETY

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10.1136/leader-2018-FMLM.28

My time as Lessons Learnt (LL) Lead has illustrated both how leadership can serve to improve patient safety and the role of reflection in ongoing development as a junior leader.

'Lessons Learnt: Building a Safer Foundation comprises an NHS patient safety training programme, wherein Foundation trainees lead a peer-group discussion and analysis of a patient safety incident (PSI) in a safe, facilitated forum'. I facilitated discussion around incidents raised by participants, ranging from analgesia delay for fracture patients, to missed diagnosis of a rare and sadly fatal chemotherapy side-effect. Our objectives were focussed around acquiring patient safety knowledge, skills and attitudes.

The project appeared to garner positive feedback. However, something changed two or three sessions in: motivation dropped. Despite excellent speakers, there was a fatigue in engagement. Holding group and individual discussions, I identified that LL sessions left participants feeling like there wasn't enough action – what are we actually doing to help patients?

One objective in the LL course guide states: 'raise and act on concerns about patient safety'. I decided to make this a priority by including a larger element of quality improvement. In the final LL session of the year we looked back over PSIs and identified what could be actioned in the form of a QI project. With participants in smaller groups, I tasked each group to create a SMART aim, a measure for said aim and a timescale. Projects are ongoing around the themes of safe prescription, inter-staff communication and awareness of safety protocols. Feedback has been overwhelmingly positive.

My leadership lessons throughout the process:

- set wider team goals overarching regular session objectives
- team demotivation is something to be explored, not feared
- engaging and useful feedback, though time-consuming, can make all the difference
- use methodology that participants know well to bridge gaps in progress.

Call for posters – developing effective leaders

29 DEVELOPING A TRAINEE-LED REGIONAL LEADERSHIP AND MANAGEMENT SERIES FOR RHEUMATOLOGY SPECIALTY TRAINEES

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10.1136/leader-2018-FMLM.29

Background We identified an unmet need in regular formal teaching provided by Health Education England North West