improve quality of care for diabetic patients in the appropriate setting.

Diabetes care is estimated to account for at least 5% of UK total healthcare expenditure, and up to 10% of NHS expenditure. Specifically, each outpatient appointment costs on average £115., thus reducing inappropriate patient loads provides considerable cost savings for the trust. This model could be translated across to other departments and other trusts to optimise and improve the quality of care for many thousands of patients.

Developing effective leaders

68 THIS PROGRAMME WAS DELIVERED THROUGH THE GSTT SCHOOL OF IMPROVEMENT (POSTGRADUATE MEDICAL EDUCATION) IN A LONDON TEACHING HOSPITAL WITH A LARGE COHORT OF FOUNDATION AND SPECIALIST TRAINEE DOCTORS. THE MOST RECENT NATIONAL TRAINEE SURVEY 2018 HAS DOCUMENTED

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This programme was delivered through the GSTT School of Improvement (Postgraduate Medical Education) in a London teaching hospital with a large cohort of foundation and specialist trainee doctors. The most recent national trainee survey 2018 has documented that significant numbers of doctors in training are burnt out and stressed by their clinical work. This impacts on the quality and safety of care provided in an already 'stressed NHS'. Resilience workshops were delivered as part of mandatory training (through a bespoke, evidence based workshop) for all foundation year doctors and the trust's junior doctor leadership group. Follow up with qualitative questionnaire occurred after the workshop.

Questionnaires were used to collect quantitative and qualitative data from participants at three time points: immediately prior the workshop (baseline), immediately after the workshop (post workshop), and two months after the workshop (follow-up). Outcome measures collected included perceived stress and positive well-being scales.

The participants reported high levels of stress at baseline with comparisons between baseline and 2 month follow-up questionnaires revealing improved stress levels and well-being ratings. 81% of participants felt that that topics covered were useful for their work and over three-quarters of participant said that they intended to use some of the techniques they had learnt on the workshop. 76% of those who completed a follow-up questionnaire had actually done something differently.

This workshop which covered the neurobiology of resilience, the performance curve and a resilience inventory was particularly suited to addressing the needs of doctors who are familiar with the science behind evidence based interventions. This systemic approach to addressing resilience across the workforce needs to be an integrated generic component of postgraduate medical training if we are to future proof the NHS to continue delivering high quality, safe care to patients.

Leading innovation and improvement

69 OPERATING THEATRE QUALITY IMPROVEMENT FOR SUSTAINABLE INCREASES IN PATIENT SAFETY AND EFFICIENCY: A REALIST REVIEW

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Introduction The ever-increasing demand for NHS services alongside heavy financial pressures makes the focus on health-care quality more important than ever before. Patient safety and efficiency are key domains of quality improvement (QI), especially in the operating theatre setting. Operating theatres, being the costliest departments in hospitals are an ideal focus for efficiency gains. The current financial climate of the NHS necessitates a focus on efficiency, whilst also keeping patient safety at the centre of attention.

Aim This review aims to address the question of sustainability in quality improvement, focusing on the two closely linked domains of patient safety and efficiency in the operating theatre setting.

Method This study was a realist review of qualitative and quantitative evidence. Data saturation was reached at 26 papers, however a further 5 studies were fully analysed to confirm this. 8 studies focused on non-technical skills training, 6 focused on checklist implementation, 8 considered process or workflow redesign, and 9 studies relied on other methods. It must be noted however that although interventions are grouped as such, there is significant variability within, and overlap between groups, with some interventions being more complex and incorporating multiple tools as part of the same intervention.

Conclusion The two main concepts to consider refined throughout the review are as follows:

- A culture of continuous, data-driven quality improvement considering staff needs and perceptions, with support from all levels of an institution, can produce sustained increases in both efficiency and patient safety. Process integration is a vital component of sustainable QI in all stages of planning and implementation.
- Quality improvement strategies can target patient safety and efficiency in combination, without significant compromise. Consideration of both domains can help align the goals of different stakeholders, enhancing positive staff perceptions and thus participation, resulting in sustained uptake.

An integrated leadership training programme

70 TOMORROWS LEADERS, MAXIMISING POTENTIAL – AN INTEGRATED LEADERSHIP TRAINING PROGRAMME

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The junior doctor leadership group (JDLG) was developed within a London teaching hospital for a cohort of junior doctors and local management trainees. This leadership

development programme is supported by the GSTT School of Improvement (Postgraduate Medical Education). Despite the importance of leadership and management in delivering high-quality care, focused, meaningful and experiential leadership development has not been integrated within speciality training. Understanding the NHS landscape and quality and cost of care are essential for developing the leaders of tomorrow. National programmes such as the National Medical Directors and Darzi Fellowship, have been successful. However, they are oversubscribed and feedback suggests shorter or more integrated programmes may help those who are unable to commit to a year-long programme.

The JDLG was set up within the trust with a 2 day immersion workshop including Barry Oshrey's Powerlab and MBTI. This was followed up with four half day sessions supporting skills around quality improvement, transformation and change management and basic knowledge of finance. Presentation and feedback on individual QI projects enable a qualitative and financial impact assessment of the projects undertaken. During the last CQC visit, the leadership development opportunities for staff were commended. The JDLG provided evidence for this assessment and this model of leadership development has been adopted at two other hospitals.

Coordinating a multi-disciplinary programme can align the values and vision of organisations. Leadership development and quality improvement training should be integrated into the generic core curriculum for medical training. With support from postgraduate medical education directorates, these programmes can be set up as a small or large-scale programme with minimal resources. We are happy to share the programme framework to support trusts who would like to initiate something similar.

Leading across systems and organisations

71 DEVELOPING THE HOSPITAL AT NIGHT SERVICE AT QUEEN ELIZABETH HOSPITAL – AN EXAMPLE OF EFFECTIVE JUNIOR DOCTOR LEADERSHIP

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The Hospital at Night (H@N) model is an established system of providing clinical care overnight.¹ Queen Elizabeth Hospital is a busy district general hospital in South East London. The H@N project was started in 2017 by a multidisciplinary working group which has delivered interventions using PDSA (Plan, Do, Study, Act) quality improvement methodology.²

Intervention 1 – January 2017: Regular H@N meetings became standard practice; bringing together medical, outreach and site manager teams.

Intervention 2 – February 2017: Introduction of structured checklist; location changed to site manager's office; '10 min warning' bleep introduced to signal meeting start. An audit demonstrated reduction in the average handover duration (figure 1).

Intervention 3 – June 2017: Checklist modified to include information on hospital state. Trust-wide policy document created. Further audit demonstrated the improvements in handover duration were maintained and the handover checklist was consistently used (figure 2).

Intervention 4 – June 2018: Invitation extended for other specialties to attend; meeting time changed to encourage attendance; 'Bleep filtering' by site managers to reduce junior doctor workload. Informal feedback is that these changes have adversely affected the meeting flow and not improved speciality attendance. Further interventions are planned.

Lessons learned Junior doctor leadership: Junior doctors have been key to the project and their experiences from different departments are behind the innovations. The project has provided them with experience in quality improvement and in drafting policy.

Multi-disciplinary working group: Each member brings a different insight and has allowed interventions to be bolder. Staff engagement has been challenging and team members have needed to develop and utilise their leadership skills.

Promoting 'on the ground' leadership: The bleep filtering system was designed to use the knowledge and leadership skills of senior staff to more effectively utilise their staff and has given them an insight into development needs.

Abstract 71 Figure 1 Timeline of average duration of handover meeting (in minutes) with interventions labeled

Abstract 71 Figure 2 Average handover checklist completion rates (percentage) per month with interventions labeled