

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

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

James Maguire*, Ruth Eyres, Jacqui Simms, Osman Younus, Tony Rogers, Juliette Harding, Mercy Doni-Kwame. *Lewisham and Greenwich NHS Trust, UK*

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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).

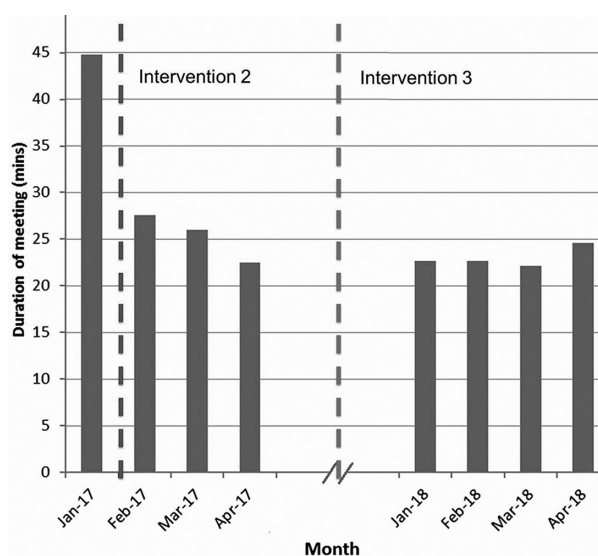
Intervention 3 – June 2017: Checklist modified to include information on hospital state. Trust-wide policy document created. Further audit demonstrated the improvements in hand-over duration were maintained and the handover checklist was consistently used (figure 2).

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.

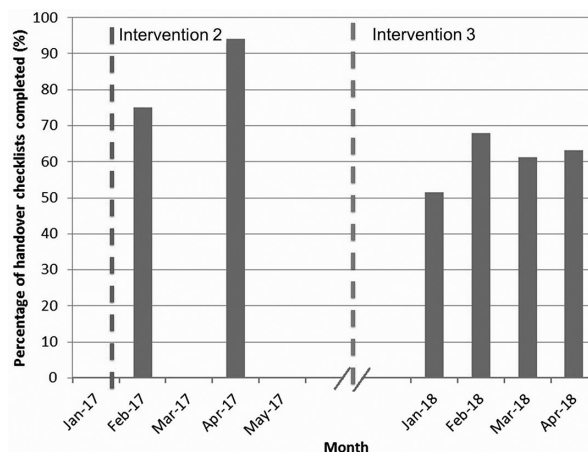
Lessons learned Junior doctor leadership: Junior doctors have been key to the project and their experiences from different departments are behind the innovations. The project has provided them with experience in quality improvement and in drafting policy.

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