Leadership curricula

72 ASPECTS OF LEADERSHIP BEST LEARNT AT MEDICAL SCHOOL AND HOW THESE RELATE TO AUSTRALIAN MEDICAL COUNCIL GRADUATE OUTCOMES

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Introduction/background Leadership is a core competency of doctors. However, specific learning outcomes for leadership are not well defined in medical school curricula in New Zealand and Australia.

Aim

1. Define learning outcomes (LOs) for leadership in pre-qualification medical curricula
2. Evaluate the extent to which Australian Medical Council (AMC) standards meet LOs for medical leadership

Methods After conducting a literature search the UK's Medical Leadership Competency Framework (MLCF) was selected as the 'gold standard' framework.

Each author assessed whether relevant AMC standards sufficiently aligned to each MLCF domain, and consensus was achieved.

Results

1. No clear 1:1 relationship between AMC and MLCF LOs. Many standards were too general or too specific. Significant interpretation of LO intent was required.
2. Many existing AMC outcomes fit within the leadership framework. These could be more explicit.
3. Some key elements of leadership are not yet encapsulated by AMC LOs (e.g. tools for system improvement/audit).
4. Many MLCF competencies could be introduced into medical school curricula as foundations for further development after graduation.
5. Some MLCF competencies are more effectively learnt after graduation.

Conclusions Leadership is multidimensional. Some dimensions may be more appropriately learnt after medical school. There are however significant gaps in current curricula as defined by the AMC, which could be met more effectively using the MLCF guidance.

Discussion MLCF leadership domains are not yet sufficiently aligned to current AMC standards. This suggests further work is required to ensure medical curricula meet the leadership needs of our graduates.

Leadership development

73 THE OXFORD FUTURE LEADERS PROGRAMME: A MIXED-METHODS EVALUATION

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Background The Future Leaders Programme (FLP) was a leadership and organisational change training programme for

newly appointed consultants at the Oxford University Hospitals NHS Foundation Trust (OUH). It aimed to equip new consultants with skills, knowledge and experience to lead sustainable change, and was centred around quality improvement projects as a vehicle for skill development and a metric of outcomes.

The FLP was developed with blended learning techniques. It consisted of a series of monthly full-day workshops over 12 months with discussions, lectures, workshops, experiential learning, simulation, and mentoring.

Evaluation Evaluation was conducted with a mixed-methods approach based on Kirkpatrick's framework for evaluation of educational outcomes: (Harden, Grant and Buck, 1999; Hammick, Dornan and Steinert, 2010)

- Levels 1 and 2 (Reaction/Learning)
 - Questionnaire based on Pendleton and Furnham's Primary Colours model (Pendleton and Furnham, 2016)
- Level 3 (Behavioural Change)
 - Post-course questionnaire; interviews
- Level 4 (System)
 - QI project outcomes

Results 24 participants completed FLP2, in 6 project teams. 85% reported working over the allocated 4 hours per week (68% worked more than 4 hours over) Despite this, 100% of respondents reported an increase in motivation, 95% reported an increase in confidence, and 84% reported an increase in job satisfaction and resilience. 88% of individual average scores across the Pendleton and Furnham questionnaire reduced over the course. A change in reference frame was indicated by questions regarding knowledge of strategy. 3/6 (50%) QIPs showed clear improvement and 5/6 (83%) showed some improvement. Independent financial analysis showed a clear return on investment (ROI) for the course.

Conclusions Despite increased workload associated with a leadership course, these results show that it is possible to generate positive individual, organisational and patient outcomes, with positive ROI.

Further study is needed to investigate factors that influence the success of such programmes, and to investigate reference frame changes that might explain the overall decrease in self-assessed scores shown.

REFERENCES

1. Hammick M, Dornan T, Steinert Y. Conducting a best evidence systematic review. Part 1: From idea to data coding. BEME Guide No. 13. *Medical Teacher* 2010;32(1):3–15. doi:10.3109/01421590903414245
2. Harden R, Grant J, Buck G. BEME Guide No. 1: Best evidence medical education. *Medical Teacher* 1999;21(6):553–562. doi:10.1080/01421599978960
3. Pendleton D, Furnham A. *Leadership?: All You Need To Know* 2016.

Enhancing your leadership skills

74 LEADERSHIP STRATEGIES FOR ADDRESSING UNPROFESSIONAL BEHAVIOUR IN HEALTHCARE

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Unprofessional behaviour occurs when 'the use of inappropriate words, actions or inactions by a physician interferes with

teamwork and quality healthcare delivery safety'. Unprofessional behaviour impacts on patient experience and outcomes, contributes to poor teamwork and increases the risk of complaints and litigation. Most clinicians do not present problems but recurrent incidents involving the same individuals are common.

Responsibility for recognising and managing unprofessional behaviour should be encouraged at all levels of the health-care system however clinical leaders have a particular role in both modelling professional behaviours and managing individuals and departments. Clinical leaders benefit from having policies in place for dealing with unprofessional behaviour which must have the approval and endorsement of the executive leadership team. Policies are required to be transparent, consistent and fair. Screening for health and other issues is an important early intervention in managing unprofessional behaviours. Leaders need to be aware of where to find support for doctors with health or related issues. The evidence suggests that a graduated response is most effective for managing the majority of disruptive behaviours except in the case of single egregious acts such as a sexual or physical assault. Leaders need to be supported and have the necessary training to develop skills in managing unprofessional behaviours. Organisations have an obligation to provide access to human resources, legal and occupation health advice for those directly managing doctors who display unprofessional behaviours. Clinical leaders with roles in colleges, regulatory organisation and policy directorates also play an important role in creating and promoting a culture in which professionalism can thrive.

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managing the majority of disruptive behaviours except in the case of single egregious acts such as a sexual or physical assault. Leaders need to be supported and have the necessary training to develop skills in managing unprofessional behaviours. Organisations have an obligation to provide access to human resources, legal and occupation health advice for those directly leading doctors who display unprofessional behaviours. Clinical leaders with roles in colleges, regulatory organisation and policy directorates also play an essential role in creating and promoting a culture in which professionalism can thrive.

Call for posters – leading innovation and improvement

76 GOING WITH THE FLOW: IMPROVING OUTCOMES FOR INPATIENTS WITH URGENT GASTROENTEROLOGICAL ISSUES BY OPTIMISING FOR TIME TO SPECIALTY

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Aims To improve outcomes of patients with emergency Gastroenterology diagnoses through optimising 'Time to Specialty' using a Plan-Do-Study-Act (PDSA) approach.

Methods This outcome measure was initially identified from personal experience of some of the authors. To justify it we collected data on patients admitted with flares of ulcerative colitis in the past year and found a strong positive correlation between length of stay (LOS) and the amount of time a patient spent outside of our specialist gastroenterology ward (Pearson correlation coefficient=0.68). We shall refer to this latter measure as Time to Specialty, our outcome measure.

We identified key moments in a patient's journey using a flow diagram and attempted to optimise them separately, measuring the effect on Time to Specialty. We identified teams involved in the admission and transfer process at each stage and engaged with them to collaboratively solve challenges. After talking to the relevant parties we created a solution that would impose a minimum of extra work as well as meeting the incentives of the different teams involved.

Results We received immediate positive feedback from the teams involved, who found that our electronic solution lifted some of the administrative burden from a pen-and-paper process. The data showed a marked improvement in the Time to Specialty for our urgent cases from 3.6 days to 0.5 days. This was matched with an improvement in average LOS from 13.9 days to 7.0 days for these urgent cases with no overall impact on LOS for the other patients.

Conclusion This project demonstrates a successful model for measuring specialty responsiveness as well as some steps that improved responsiveness in our local milieu. We hope that Time to Specialty, the time before an inpatient is taken over by the specialty team, will become a widely-used outcome measure for acute presentations where intensive specialty support is required.