Guest presentations were given by NHS healthcare leaders and QIPs were mentored by hospital consultants with experience in leadership and quality improvement.

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)
 - Self-assessment questionnaires based on Pendleton and Furnham's Primary Colours model (2016)
- Level 3 (Behavioural Change)
 - Post-course questionnaire; interviews
- Level 4 (System)
 - Quality Improvement Project outcomes.

Results Course participants found the combination of workshops and practical work engaging.

Many participants struggled to arrange their clinical duties to attend all workshops.

Self-assessment results showed an increase in leadership capacity, with statistically significant increases in 50% of domains. There were large increases related to strategy, alignment and relationships with managers.

Confidence, motivation and job satisfaction rose amongst participants.

Objective improvements were demonstrated in 2/4 QIP's.

Conclusions By aligning the programme with organisational goals (Quality Improvement) course faculty were able to access support and development opportunities to the benefit of the organisation, the individuals and their patients.

A solution to workshop timing problems continues to elude faculty.

A longer timeframe could support course outcomes.

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Leading innovation and improvement

80 THE ACUTELY UNWELL PATIENT – HOW CAN WE IMPROVE JUNIOR DOCTOR ASSESSMENT AND RECORD-KEEPING TO IMPROVE PATIENT SAFETY

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When patients become acutely unwell on the ward, it is often a Foundation (FY1/2) doctor who assesses initially. Doctors are encouraged to use the 'Airway, Breathing, Circulation, Disability, Exposure' (A-E) approach to assess. The pressured nature of reviewing patients may lead to incomplete assessment.

We aimed to introduce a proforma to improve assessment of unwell patients on orthopaedic wards, based around GMC guidelines for assessment.

Plan-Do-Study-Act (PDSA) cycle 1: Surveyed junior doctors.

50% didn't use an A-E approach when documenting reviews. 63% would use a proforma for documentation. 75% thought it would be useful and increase their confidence communicating with seniors. All believed it would improve documentation.

Cycle 2: Pre-proforma assessment/documentation.

85% were reviewed by FY1/FY2 doctors, with 15% subsequently reviewed by a senior. There was inadequate patient identification in 30%. No contact details were documented in 90%. Reason for review was always documented; A-E approach was used in 55%. Essential aspects were missed (Airway patency – 55%; Heart rate – 50%; chest exam – 30%). Impression was noted in 45%. Reviews were highlighted on ward rounds in 10% of cases and it was never documented that information was given to the patient.

Cycle 3: Post-proforma assessment/documentation.

60% were reviewed by a FY1/FY2, with 80% subsequently reviewed by a senior. Patient identification increased to 100% and documentation of reviewers' contact details to 80%. Use of A-E approach and documentation of impression increased to 100%. Acknowledgment of previous review on ward rounds was 85% and information was provided to the patient in 80%.

Cycle 4: Surveyed doctors.

67% felt the proforma improved assessment, communication with seniors, and identification of patients reviewed during subsequent ward rounds. All felt it improved documentation.

An A-E proforma can improve care and documentation.

We will continue to analyse proforma use at 4 weekly intervals through PDSA cycles.

81 THE LITTLE THINGS THAT SHOW WE CARE: STAFF ENGAGEMENT AND CAREER DEVELOPMENT

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Introduction Staff development and engagement is one of the sure ways to ensure you can retain your staff, uplift moral and obtain patient satisfaction.

At the National staff engagement forum in 2016 staff engagement was described as; 'Staff are engaged when they feel valued...and say matters and makes a difference'.

Taking the challenges of busy clinical work, we aimed to provide our cohort of NCHD's the chance to provide us with feedback on a proposed session we deemed to be of interest to NCHD's through a 3 phased survey study.

Aims

- To identify a gap in NCHD's career development and to provide a program to fill this need at no cost to NCHD's.

Methods 3-phased survey was conducted; first phase needs analysis and NCHD requirement of proposed event. Second phase survey is post event evaluation and analysis of event success and relevance. Third phase survey was aimed to