Assessment of issue Informal interviews revealed that interruptions from various team members, as they enter the trauma bay, to the trauma team leader (TTL) was felt to contribute to poor communication and teamwork. Digital monitors in the trauma bay at our institution were therefore introduced to display information using the 'ATMIST (Age, Time, Mechanism, Injury, Signs, Treatment)' mnemonic. Unfortunately, uptake had been poor, being used in only half of the cases.

Strategy for improvement We identified factors (figure 1) contributing to the inconsistent use of the ATMIST tool and then implemented various strategies to improve use of the tool such as we increased awareness by email communication and added the ATMIST tool as pre-arrival checkbox to the trauma intake form. Improvement of interventions were studied through structured observation of traumas. The outcome measure was defined as the proportion of total trauma activations with ATMIST tool partially or fully completed. Additional measures included number of interruptions to TTL (clinical measure), number of incorrectly entered items (balancing measure), and TTL satisfaction (qualitative measure). There was an increased use of the ATMIST tool from 50% to 66% in a 2 month period following all interventions. Interruptions to the TTL were observed less frequently and there was no increase in incorrect items displayed.

Abstract 17 Figure 1

Lessons learnt Continuous QI methodology help identify obstacles and strategies to improve overall care. More trauma observations and further PDSA cycles, now that strategies have been implemented, are required in order to determine whether the tool continues to be used, reduces TTL interruptions, improves overall communication and teamwork.

Leading innovation and improvement – emergency medicine

18 FLEXIBLE FIT ZONES: MAKING A&E FIT FOR PURPOSE

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10.1136/leader-2018-FMLM.18

Introduction Emergency Departments (ED) attendances are rising year-on-year. Innovative measures are needed to improve capacity and continue to meet the 95% 4 hour target in the context of limited resources.

Methods North Middlesex University Hospital ED introduced 3 key interventions to improve performance. Two cubicles were converted to a seated treatment area. Adjacent to this staff and cubicles were specifically designated for ambulance handovers, this was coined the Fast Initial Treatment (FIT) Zone.

Interventions

1. Fit2Sit assessments determined if ambulance arrivals could be treated in a seated area rather than cubicles
2. The flexible FIT Zone would 'expand' or 'contract' with reallocation of space and staff according to rate of ambulance arrivals
3. Direct referrals of stable patients from ED triage to specialty assessment areas

Grip and control was required in the novel areas during initial stages of intervention. A team of FIT Zone specialists initially oversaw implementation during a pilot period. A series of information and teaching sessions then informed and engaged colleagues about interventions to make distributed leaders ahead of extending the pilot.

Results 54% of non-blue light ambulance patients were 'Fit2-Sit' and treated in chairs, optimizing use of space. 15% of patients were processed during 'expansion periods'. Ambulance handover time improved (−18%) as well as Time to initial assessment (−45%), Time to see a clinician (−17%), and Time to referral (−12%). 4 hour performance 100 days after intervention had improved from 74% to 84%.

Staff feedback indicated that the department ran more efficiently (+28%), job-satisfaction had improved (+13%), perceived quality of care delivered had improved (+15%), and space was less frequently an issue (+26%).

Conclusion Fit2Sit assessments, FIT Zones, and direct referrals alongside a distributed leadership models can lead to improvements in ED performance, staff satisfaction, and ambulance handover time.

Developing effective leaders

19 THE EVOLUTION OF A LEADERSHIP DEVELOPMENT PROGRAMME FOR ASPIRING CONSULTANTS IN A MENTAL HEALTH TRUST

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10.1136/leader-2018-FMLM.19

We describe the evolution of a leadership training programme in a mental health trust, from one designed to meet the needs of the medical leadership curriculum to a multi-disciplinary programme for aspiring consultants across all disciplines. Earlier work had demonstrated that higher trainees in psychiatry often reported not being prepared for consultant leadership responsibility. The medical leadership competency framework (MCLF) provided a structure against which a programme could be designed and evaluated. We invited all senior registrars working in the Trust to join a pilot programme in 2011.