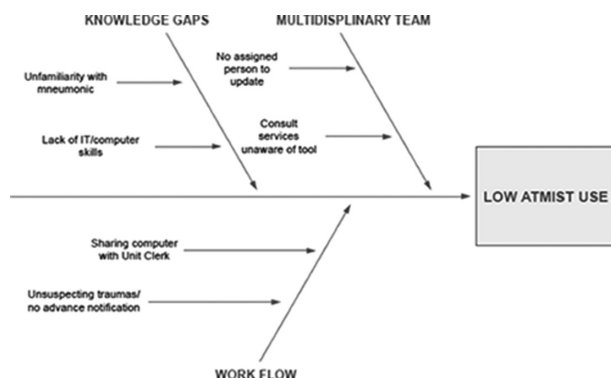


Assessment of issue Informal interviews revealed that interruptions from various team members, as they enter the trauma bay, to the trauma team leader (TTL) was felt to contribute to poor communication and teamwork. Digital monitors in the trauma bay at our institution were therefore introduced to display 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

¹Max Denning MRCS*, ²James Harrison FRCEM, ²Andres Martin MRCS FRCEM. ¹Imperial College London; ²North Middlesex University Hospital Accident and Emergency Department

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 'Fit2Sit' 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

Lenny Cornwall*, Jim Boylan, Wendy Cowie, Bryan O'Leary. Tees, Esk and Wear Valleys NHS Foundation Trust

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.

The programme has two elements: a workshop-based taught programme and an experiential leadership project. The taught programme consists of 6 whole day workshops covering topics such as leadership style, difficult conversations, emotional intelligence, and change management. We have run the programme over 6 cohorts. In the 3rd cohort the invite was extended to senior non-medical staff and the framework used moved from the MCLF to the Health Leadership Model (HLM). 159 senior registrars, 11 specialty doctors and 30 non-medical mental health professionals have completed the programme.

The programme was evaluated by self-assessment of leadership attributes across the 20 elements of the MCLF. We used χ^2 test to compare the proportion of participants reporting being effective on each element before and after the programme. There was a highly significant increase in the proportion of participants meeting competency in 18 of the 20 elements ($p < 0.001$). The largest increases were shown in the managing services and improving services domains.

We have now been able to set a common standard for leadership competency for consultant practitioners irrespective of professional background based on the HLM. The critical elements for the success of the programme can be attributed to a sound theoretical curriculum and a blend of workshop and workplace-based learning experiences and mentorship.

Leading innovation and improvement

20 IMPROVING OPERATION NOTE STANDARDS

Sachi Vinodkumar Shah*, Husam Ebied. *St Thomas' Hospital, Guy's and St Thomas' NHS Foundation Trust, UK*

10.1136/leader-2018-FMLM.20

Background High standards of operation notes that are accurate, comprehensive and legible are essential for continuity of care. St Thomas' hospital uses an almost fully electronic system for patient records. However, operation notes are hand written onto blank paper. They often lack sufficient detail, posing a threat to patient safety.

Aims The Royal College of Surgeons England (RCSEng) defines an 18-point criteria that should be included in an operation note. The aim was to assess and improve compliance of operation notes at St Thomas' hospital with the RCSEng guidelines.

Methods and intervention A retrospective review of operation notes of laparoscopic appendicectomies was conducted over a 3 month period from June 2017 – September 2017. A proforma was designed to include the RCSEng criteria. This involved several meetings with consultant surgeons. A second audit cycle was conducted on all proformas used during a 3 month period from February 2018 – April 2018.

Results A total of 75 operation notes were reviewed. Proforma use showed a statistically significant increase in average compliance from 51% to 98.9% ($p < 0.0001$). There was at least 90% compliance in all 18 criteria and 10 out of 18 criteria showed statistically significant increase.

Discussion This is the first standardised operation note in the department. Liaison with the School of Improvement and IT services is allowing the template to be modified into an electronic proforma which can be used for all surgical procedures. Excellent leadership and negotiation allowed an 'easy' yet unsafe system to be improved with approval of consultants.

Conclusion Junior doctors often encounter system failures first-hand which can directly affect patient care. There is a general assumption that innovation is governed at a higher level. With good leadership and communication from junior doctors, a simple idea can be built up to a larger scale with a significant impact on patient safety.

Organisational culture

21 THE DIAGNOSIS OF ORGANISATIONAL CULTURE WITHIN AN NHS EMERGENCY DEPARTMENT

Brian Armstrong*, John Maxwell, Eoghan Ferrie, Linsey Sheerin. *Royal Victoria Hospital, Belfast, and University of Ulster, UK*

10.1136/leader-2018-FMLM.21

The academic literature demonstrates that organisational culture contributes to variation between health care organisations in outcomes and performance, including patient satisfaction, innovation, health care quality and safety, and employee job satisfaction. The objectives of this study were as follows: 1. To review literature on organisational culture within the NHS and to identify key themes relating to cultural change, service improvement and collective leadership. 2. To identify the dominant culture within the RVH Adult Emergency Department by using a combination of both the 'Organisational Culture Assessment Instrument' (OCAI) and 'Rich Pictures' soft systems methodology. 3. To formulate recommendations. The results of this study indicates the dominant organisational culture is a market culture (29.74 points), followed by hierarchy culture (28.97 points) then a clan culture (25.55 points) and an adhocracy culture (15.74 points), this infersthat there is a mixture of cultures where an emphasis is placed predominantly on results and profitability. The results also look at the difference between current and preferred organisational culture. The largest desired difference can be seen in clan culture, with an increase of 12.93 points. Subsequently market culture with a decrease of 12.39 points. Hierarchy culture decreases with 3.58 points and adhocracy culture increases with 3.04 points. The dominant culture in the preferred situation becomes clan culture, followed by hierarchy culture, adhocracy culture, and market culture. The results also show there was a differing gap within all professional groupings with admin staff (24.97 points), doctors (33.71 points), nurses (40.36 points) and others (11.08 points). The Rich Pictures results highlight contrasting multidisciplinary dynamics in regards to hierarchy, inter team cooperation and a team whom whilst working under extreme pressure, were positively committed to quality, patient safety and service innovation.