we investigated L&M experiences amongst a group of junior doctors.

Method We surveyed 97 junior doctors in a teaching hospital in Devon to ascertain their opinions of healthcare L&M and to quantify their opportunities for leadership. Multiple choice and free-text answers were analysed using quantitative and qualitative methods.

Results The majority of respondents were aged under 30, FY1 - CT2 grades and based in Medical, General Practice and Obstetrics and Gynaecology training posts.

Leadership and management were considered important for both career development and clinical practice, despite a lack of L&M training or formal leadership roles (93%). Most respondents (71%) cited a paucity of L&M development within clinical training programmes, with most respondents describing average to poor opportunities to develop these skills (91%).

Trainees exhibited leadership most during: ward rounds (74%); quality improvement and audit work (73%); board rounds (55%); mentoring sessions (39%); and on-call work (26%). Most would welcome further L&M training, preferring grade-specific sessions (84%) and regional courses (61%) over other forms of training. However, few were aware of local and national medical leadership initiatives, bodies and programmes.

Conclusion The majority of junior doctors surveyed valued L&M experience for future success and also demonstrated evidence of providing leadership, despite lacking formal leadership training. Clinical training programmes need to focus on developing these skills alongside raising awareness of the opportunities available for leadership development. The challenge remains as to how this can be achieved whilst balancing training and service commitments.

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THE QUALITIES OF A GOOD LEADER: VIEWS OF JUNIOR DOCTORS

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Introduction There is a growing emphasis on developing effective leadership within healthcare, including better training and support for clinical leaders.¹ The views and experiences of senior NHS leaders have recently been explored^{2,3}; however, junior doctors remain an untapped resource. In order to develop our trainees into future clinical leaders, it is important to explore their current understanding of leadership.

Methods We surveyed 97 junior doctors at a teaching hospital in Devon. Respondents identified skills and qualities they associated with good leadership and also described how they exhibit leadership during daily practice. The free-text responses received were then appraised within contemporary

leadership theory. Respondents were mainly aged 21–30, FY1 - CT2 trainees and from General Practice, Medical Training (Core & Specialty) and Obstetrics and Gynaecology programmes.

Results Juniors' definitions of effective clinical leadership valued communication and teamwork skills over more technical proficiencies. Approachability and inclusivity were also highly valued, along with attributes associated with compassion, the development of others, consultative leadership and active followership.

The junior doctors surveyed described their personal clinical leadership as a network of relationships and connections rather than single projects or set hierarchical roles. However, many failed to identify any examples of personal leadership, citing a lack of experience and isolated working in community settings.

Conclusion This survey has explored junior doctors' perceptions and experiences of leadership. Trainees valued collaboration skills and characteristics associated with the creation of a strong social identity, active followership and distributive leadership.⁴ These align with a transformational leadership style, compared with the more traditional, transactional leadership approach favoured during a study of their peers over a decade ago.⁵

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Developing Effective Leaders

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A PATIENT CENTRED PATHWAY WITH AN IMPROVED OUTCOME

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10.1136/leader-2019-FMLM.41

The Department of Health's Strategy for cancer services sets out an ambitious aim for the NHS to make significant progress in reducing preventable cancers, increasing cancer survival and improving patient experience and quality of life by 2020. The 'two-week wait' (2ww) cancer referral system has been in place for more than 10 years to help deliver the best outcome in a stipulated time frame for each patient.

Like many organisations, our team at South Tyneside District Hospital in the north east of the UK, struggle to maintain a compliant performance on a consistent basis despite

providing excellent cancer care. As a result, our multidisciplinary team looked at our current pathway and evaluated it against best practices, recent directives and programmes such as the Accelerate, Coordinate, and Evaluate (ACE) Programme. The ACE programme encourages the utilisation of Straight-to-Test (STT) to improve time to diagnosis, and so we challenged ourselves to implement it effectively by appointing a dedicated 'Pathway Coordinator' (Band 6 Nurse).

The coordinator receives referrals, triages them with consultants, and then places them either into clinics or directly to investigations (STT). They also conduct a pre-procedure assessment over telephone within 48–72 hours that helps confirm the patient's indication, fitness and willingness to have a definitive test. By collecting and comparing data on whether patients attend clinic or go directly to scope and how long it takes for them to receive treatment, before and after the new job role, we can accurately assess the new pathways' direct impact on patients receiving treatment.

Initial Results showed that nearly half of patients went straight to test, with an improved number of days between referral and scope and referral and diagnosis, indicating that adapting this patient centred approach through a targeted role effectively addresses some of the challenges that the 2ww pathway presents.

42 DEVELOPING THE 'F3' PROGRAM AT ROYAL SURREY COUNTY HOSPITAL (RSCH)

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10.1136/leader-2019-FMLM.42

Introduction As the downward trend in the number of Foundation Year 2 doctors progressing directly to speciality training continues, NHS trusts are left struggling with rota gaps and reliant on locums. The Royal Surrey County Hospital (RSCH) is no exception. This project aimed to understand why current F2s have decided to take time out and their aims for the coming year. This information then informs the development of an attractive Foundation Year 3 (F3) program that benefits both the trust and the doctor.

Method A list of current F2s was provided by the Medical Education department. A survey was sent using Survey Monkey. Responders were asked both multiple choice and ranking questions. These concerned: their plans for the coming year, what they are hoping to get out of the coming year, and what they would look for in a trust grade position. Results were analysed and graphically represented using Microsoft Excel.

Results 25 doctors responded to the survey. Five are going directly into training; the remaining 20 are taking a year out. There are several reasons for this but the most common was to improve work life balance with 70% citing this as a reason. Just over half also want to travel. More doctors are considering locum work over trust grade employment. Competitive pay and choice of speciality are the most important factors for doctors when considering trust grade appointment. Flexibility in contract length is also an important factor.

Conclusion Only 20% of doctors in this cohort are going into speciality training. There are multifactorial reasons for this but most are seeking to improve work life balance. Many doctors

are looking to take up service posts in the UK before making use of the greater flexibility to travel Doctors favour locuming over trust grade appointment but trust grades can be made more attractive by offering flexible contract lengths, competitive pay and choice of speciality.

Leading Across Systems and Organisations

43 HOW TO STOP GUIDELINES FROM GATHERING DUST ON THE SHELF: EVIDENCE-BASED INTERVENTIONS

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10.1136/leader-2019-FMLM.43

The Evidence-Based Interventions Programme was established and developed as a joint enterprise between five national partners: the Academy of Medical Royal Colleges, NHS Clinical Commissioners, the National Institute for Health and Care Excellence as well as NHS England and NHS Improvement to lead national implementation of appropriate clinical intervention in an integrated health economy. The programme aims to ensure that procedures are offered appropriately in the NHS in England by using shared decision making, behavioural insights, consensus-seeking, collaboration with clinicians and commissioners, contract amendments, tariff changes and patient engagement. Lessons learned are wide ranging and emphasise the need for leadership at all levels of the health care system to inspire improvement:

1. We should ensure that procedures are offered appropriately in the NHS in England.
2. National implementation of initiatives is complex and requires diverse public and stakeholder engagement.
3. Creating nuanced messaging across diverse groups should not be shyed away from though it is challenging.

44 IMPROVEMENT SCIENCE INFORMING CLINICAL STRATEGY

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In 2015, the NHS, local councils, the Mayor and Public Health England set out their objectives for London's health and care system. National priorities were published in the NHS Long-Term Plan. London has a complex health and social care system serving 8.8 million population with high levels of inequality. A strategic partnership was formed identifying specific life outcomes and clinical priorities which will improve faster if the organisational partnerships works effectively at a 'once for London' level.

Initiatives by various organisations identified challenges relating to unwarranted variation in access, clinical practice and clinical outcomes. An effective delivery model was needed to coordinate efforts of all agencies to implement large scale change at system level.