Quality improvement, novel educational leadership project

4 LEADING EDUCATION IN A PANDEMIC – THE 'LEAP' PROJECT

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Covid 19 drove unprecedented changes in healthcare provision, necessitating a paradigm change by the healthcare workforce incorporating new clinical knowledge and rapid upskilling in competence.

The LEAP Project established a novel system for dissemination of vital role-appropriate training. Project analysis was disseminated to relevant stakeholders via departmental clinical leaders, facilitated by a Directorate Operations Centre (DOC) established at onset. This ensured integration of training within clinical care delivery. The target audience comprised multidisciplinary critical care and anaesthetic staff, and was then expanded to include the wider workforce.

Phase one involved drafting a statement of requirement and needs analysis, determined by relevant clinical and educational stakeholders as informed by recommendations from Public Health England, the Royal Colleges and Health Education England. This informed a framework of dynamic role and domain specific training. Leadership was delegated to multidisciplinary educational leads, ensuring academic rigour and credibility. Reciprocal escalation ensured consideration of workforce planning, future-proofing and sensitivity to individual concerns.

Subsequent training incorporated a multimodal educational approach. Participant feedback and formal peer review enabled reflection on earlier training delivery, enabling dynamic adaptation of training objectives to ensure relevance and consistency. Almost all 271 nurse upskilling candidates reported a significantly increased knowledge base post session. For Covid 19 teaching days, 90% of 191 candidates reported sessions were at an appropriate level of teaching. All 55 multidisciplinary simulation candidates reported 100% satisfaction.

This project dynamically considered all facets of workforce planning and care delivery. We have proven that rapid institution of a functional, multifaceted education programme in response to a crisis is both feasible and practical.

Leading innovation and improvement

5 AWARENESS OF RADIATION EXPOSURE AND IT'S ASSOCIATED RISK AMONGST EMERGENCY DEPARTMENT DOCTORS AT A DISTRICT GENERAL HOSPITAL

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During our emergency medicine rotations, we noticed that emergency department (ED) clinicians requested the largest

volume of radiological investigations (both plain-film and cross-sectional) in the hospital. Many ED clinicians did not have a robust understanding of the amount of radiation exposure (and associated risk of inducing fatal malignancy) that was associated with these investigations and therefore, patients weren't being adequately counselled.

We created a multiple-choice questionnaire that identified level of seniority amongst healthcare professionals in addition to assessing their level of knowledge regarding radiation dose exposure in common imaging modalities.

We distributed our questionnaire to ED doctors of all grades working within the ED, ranging from foundation year 2 (FY2) doctors to consultants. Subsequently, we hosted a short interactive tutorial on two separate occasions in the ED over a 3-day period in order to engage the largest proportion of initial survey respondents. Following this, we repeated the questionnaire.

Our study found that initially, ED doctors had limited awareness of the radiation exposure associated with the imaging modalities they routinely requested and also, minimal awareness of the associated risk of inducing fatal malignancy. As a result, they were unable to confidently counsel patients regarding this. Following our intervention, we found that all doctors, irrespective of grade, had increased awareness of radiation exposure associated with common imaging modalities and the associated risk of inducing fatal malignancy.

This will no doubt lead to better clinical reasoning, discussions with patients regarding risk of radiation and consequently, more patient-centred care.

Developing effective leaders

6 DESIGN AND DELIVERY OF A PILOT COMMUNICATION SKILLS WORKSHOP WITH FOCUS ON COACHING SKILLS FOR SUPERVISORS AT HOMERTON UNIVERSITY HOSPITAL, LONDON

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The COVID-19 pandemic has led to thousands of doctors being redeployed. The especially stressful circumstances of the pandemic may mean that regular debriefing with a supervisor is necessary. The onerous rota may prohibit lengthy meetings but coaching-style conversations may be a valuable adjunct in the communication between trainee and supervisor.

We developed a pilot communication skills training - with a focus on coaching skills - to enhance communication between supervisors and trainees.

2 sessions facilitated by 2 coaches were held with 22 and 13 participants respectively in the summer of 2019. Participants explored and challenged their assumptions about the positive and negative ways trainees and supervisors interact with each other. The coaches then introduced the SBI feedback framework (Situation – Behaviour – Impact) and the TGROW coaching model. Working in small groups, participants used TGROW to coach one another on issues relating to their role as supervisors, rotating as coach/coachee/observer.

TGROW is a solution-focused framework and leadership tool for structuring a coaching conversation. The acronym

describes a 5-step coaching process: Topic - Goal - Reality - Options - Will & Way forward. The aim is to catalyse insight and motivation to change and grow through asking powerful questions linked to each of the model's five steps.

65% of our supervisors on the course (n=23) have previously found it difficult to engage with trainees. Following training, 50% of our supervisors felt increased confidence in their communication skills. Attendees found the workshop to be helpful to reflect on the changing medical culture and how coaching can be used to reach across perceived divides and disengagement.

Our experience highlights some of the difficulty faced by supervisors when communicating with trainees. Coaching as a communication tool may be especially pertinent when managing the uncertainty faced during this pandemic.

Head injuries & anticoagulation

7 IMPROVING THE DOCUMENTATION OF RISK ASSESSMENTS AND DISCHARGE ADVICE IN ANTI-COAGULATED PATIENTS WITH HEAD INJURIES AND NORMAL IMAGING/HEAD INJURIES & ANTI-COAGULATION

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Background Patients on systemic anticoagulation are at risk of delayed bleeding following head injury despite normal head imaging. There are no current unified guidelines to help clinicians assess the risk of this delayed bleeding and advise patients on anticoagulation, however, a detailed trust guideline exists.

Aim We aimed to audit the documentation of risk assessments of delayed bleeding and of discharge advice to temporarily withhold or continue anticoagulation for 7 days as per local guidance across 2 sites, with a head injury and normal initial CT Head. Various interventions were implemented and subsequently re-audited with the aim of a 50% improvement in 6–9 months.

Methods We retrospectively audited 100 eligible patient encounters (Nov-Feb 2020) using patient records to assess documentation of risk assessment and discharge advice against our Trust policy. Interventions consisted of an amendment to the Trust head injury leaflet and CT Head Form Requests to include an anticoagulation section, structured teaching to raise awareness including in patients and e-mailing the local policy to all A&E staff with regular entries into the Staff Bulletin/Intranet, Induction of New Joiners and Weekly Safety Message. 50 eligible patient encounters were re-audited (Apr-Jun 2020).

Results Audit 1 revealed that 37% of encounters contained documentation of both risk assessments/discharge advice whereas 51% of encounters documented neither. Audit 2 had improved with 44% of encounters containing documentation of both and only 28% of encounters containing no documentation.

Conclusion This project demonstrates that simple measures such as education and sign-posting local guidance have the potential to improve complex decision-making and ensure adequate safety netting. Additional work is underway to identify other interventions which may improve documentation further and to ascertain the durability of these changes.

Developing effective leaders

8 CLINICAL LEADERSHIP MENTORS – A PILOT SCHEME TO IMPROVE TRAINEES' LEADERSHIP OPPORTUNITIES AND DEVELOPMENT IN THE WORKPLACE

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Introduction All doctors in training should be exposed to appropriate leadership developmental opportunities throughout their training in line with the GMC Generic Professional Capabilities framework. Leadership learning is a process of participation in increasingly complex and personally informative tasks rather than just acquisition of a pre-determined set of knowledge and skills. As part of the 70:20:10 model of leadership development we need to move learning from the classroom into the workplace providing leadership initiatives and development at every level of training.

Intervention Health Education England South West developed a Clinical Leadership Mentor (CLM) programme in 2018. The CLM is responsible for overseeing the process and progress of leadership development amongst the trainees of their Trust, creating a portfolio of leadership and management development in partnership with other stakeholders.

Strategy for Improvement CLMs required funding, support, development, and network opportunities. Financial support for 2 year pilot across all 19 Trusts in the South West supported by Regional Director HEE-SW with annual report by each CLM; achievements aligned against measured outcomes of key responsibilities. CLM network and developmental days with regional NHS Leadership Academy (NHSLA). Annual reports collated and shared within CLM network and HEE-SW. Sponsored evaluation of CLM by the NHSLA conducted by the University of Birmingham (UoB)

Impact Formal evaluation (UoB) was encouraging; CLM role perceptions were positive and appreciated by trainees and Educational Supervisors alike. Medical Managers were also committed to the role. Excellent CLM network developed across HEE-SW. Outstanding achievements in the annual reports enabled funding secured for third year. CLM development publicised as an area of Good Practice - Leads Leadership Webinar #Leadersaloud.

Quality improvement and innovation

9 OVERCOMING BARRIERS TO EXCEPTION REPORTING IN TWO DISTRICT GENERAL HOSPITALS IN THE EAST MIDLANDS; A QUALITY IMPROVEMENT PROJECT

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The 2016 junior doctor contract (JDC) implemented a system of exception reporting (ER); this allowed trainees to report missed educational opportunities, and breaches of safe working as outlined in the 2016 JDC. Foundation doctors starting