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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10.1136/leader-2020-FMLM.7

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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10.1136/leader-2020-FMLM.8

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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10.1136/leader-2020-FMLM.9

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

from 2018 will not have experienced a system prior to the implementation of the 2016 JDC and ER.

Foundation doctors filled out a survey measuring potential barriers to ER and their confidence in ER. Teaching was delivered, explaining the process of ER with a focus on the identified barriers, followed by a repeat survey to assess for change.

81 trainees attended the teaching across two hospitals. 78 trainees filled out the pre-teaching survey, with 69 completing the post-teaching survey. 47.4% had submitted an ER by the mid-point of their 2nd/4th placement. 97.1% of trainees felt the teaching addressed some of the barriers to ER; such as 'explaining the process of ER' (50.7%), 'simplifying the process of ER' (49.3%), and 'recovery of log in details' (37.7%). 69.2% of trainees felt the major barrier to ER was 'too much hassle'. 26.9% reported that senior pressure was still a barrier to ER. An improvement in confidence levels was observed with initial confidence levels (1- unconfident, 10- confident) amongst respondents at a mean value of 5.49, following the teaching this improved to a mean of 7.03. 87% of doctors felt they were more likely to exception report following this presentation.

Trainees should be encouraged to exception report to identify areas of unsafe working, so that changes can be made to address this, and provide appropriate reimbursement for additional time spent at work. To facilitate this refresher sessions should be delivered to trainees, and the process of ER reviewed to ensure that it remains streamlined. Of note, there is still a perceived culture of senior discouragement with regards to ER. Further work will focus on understanding and addressing the barriers to ER amongst supervisors.

10 IT MEETS LEADERSHIP IN ONLINE COVID WARD ROUND

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10.1136/leader-2020-FMLM.10

Context and Aim The target audience was the clinical team caring for patients suspected or confirmed of having COVID-19 at the Hatherton Centre, a secure psychiatric unit in Stafford, West Midlands. The COVID-19 pandemic presented multiple challenges: a novel disease alongside staff with little experience of managing acute medical needs for complex psychiatric patients, staff's risk of contracting or transmitting COVID, utilising staff working from home and decision making reflecting new research.

Method A twice daily virtual medical ward round was piloted using Microsoft Teams to provide medical leadership in the management of COVID-related patients for 5 separate clinical teams working in the unit. This also allowed staff working from home to be involved, information to be shared and communication improved with all involved. It further ensured that clinicians' time was spent more efficiently and minimised the risk of people moving between wards. Feedback was sought throughout and the ward round was adapted accordingly. Post-ward round feedback was sought by distributing a questionnaire to those directly involved. The questionnaire comprised nine questions comparing 'before' and 'after' the ward rounds were implemented.

Results Results showed a considerable improvement following the ward round. Staff felt more prepared, more confident, reassured with decision making, better informed and witnessed

improved team working and clear leadership. In addition staff spent less time on the ward, therefore reducing the risk of contracting/transmitting COVID. Problems, including poor internet connection, better communication to ward staff and discussion of un-related issues were resolved.

Conclusions This project shows how IT can be utilised to provide leadership and help manage new problems. It enabled staff working from home to support patients/colleagues, supported colleagues on the ward and contributed to staff well-being in a particularly challenging time.

Developing Effective Leaders

11 JUNIOR DOCTORS AS SENIOR LEADERS – LESSONS LEARNT DURING COVID-19

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10.1136/leader-2020-FMLM.11

COVID-19 presented a huge unplanned pressure on health resources worldwide. Across the NHS, different approaches have been utilised to respond to the crisis. Leadership figures across services were faced with difficult decisions with potential scarcity of resources never before seen by NHS services, particularly in relation to critical-care bed capacity.

One of the key changes implemented in the acute Trust where I am based, was the placement of a junior doctor into Trust management and Leadership teams. Under direct supervision from the Trust director team I was released from the majority of my clinical responsibilities to provide leadership and oversight into decisions affecting junior doctors. This included leading junior doctor redeployment, inducting Foundation Induction Year 1 Doctors and designing and implementing a new out-of-hours service.

As a FY2 doctor, this provided a unique experience to integrate into senior management structures and lead several projects. Coming from a baseline of poor trainee feedback across several cohorts, it was recognised that this was an opportunity to instigate a culture shift across divisions.

This article will discuss the lessons learnt from this experience, highlighting areas for improvement, with the hope of providing a road-map for empowering junior doctors to take senior leadership roles in the future.

Leading innovation and improvement in critical care

12 ISOLATED BUT NOT ALONE: CRITICAL CARE COMMUNICATION IN THE TIME OF COVID-19

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10.1136/leader-2020-FMLM.12

Many communication challenges became evident when the coronavirus pandemic led to the closure of Critical Care Units to visitors. Extra staff drafted in were unfamiliar with the ICU environment and needed to focus on direct patient care. The increased ICU footprint meant calls might be misdirected. Personal protective equipment (PPE) hampered hearing,