and Evaluation. Integral to the time capsule are signposts to resources and toolkits.

As leadership fellows, we have piloted the capsule reflecting on four different trainee perspectives:

1. Impact on training
2. Redeployment
3. Telemedicine
4. Remote working

Discussion This tool provides a template for reflective practise on our experience, realising and sharing the lessons that have been learnt. As a group of fellows, this tool was used as a 'shared experience' process exploring leadership in our various environments, learning from our experiences and realising how we can develop as leaders going forward. This reflective time capsule highlights the importance of learning from significant challenges faced during the pandemic.

Conclusion Active participation in the leadership time capsule facilitates the process of building on experiential learning during a crisis. Critical lessons from this process can inform trainee leadership development to ensure competences and confidence when facing future challenges.

Leading innovation and improvement

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JUNIOR LED DIGITAL INNOVATION: THE USE OF ATTEND ANYWHERE VIDEO CONSULTATION AT NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST

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10.1136/leader-2020-FMLM.140

For some time, despite video consultation software being available to utilise at North Staffordshire Combined Healthcare NHS Trust (NSCHT), its widespread use had not been achieved. The reasons for this were unclear as both staff and service users had previously indicated interest. With the onset of the COVID-19 pandemic and resulting lockdown, the trust needed to adapt quickly in order to maintain a high standard of care, whilst significantly reducing face to face appointments. A higher trainee and consultant in psychiatry, along with the Innovation Collaborative and research team, worked to promote and establish the use of Attend Anywhere video consultation software throughout the organisation.

A pilot study was undertaken which demonstrated a 2834% increase in the rate of video consultation across all directorates. Staff reported that the platform was effective for: assessments; delivering psychological therapy; diagnostic appointments; and for service users anxious, isolating or shielding. It was less effective for physical observation and group work. 71% of service users were satisfied/very satisfied and 75% would have more consultations using this method, despite 66% reporting problems such as poor sound. Benefits included; reduced travel time; less time off work; no stress relating to parking/attending on time; and feeling they had the sole attention of staff.

An interim report has been produced for dissemination. The next stage is to undertake focus groups with staff and service users to gain a greater understanding of how the use of video consultation software can be embedded, where appropriate, across the organisation.

Medical education

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'THE TEACHING ACADEMY'- THE EFFECT OF A PILOT TEACHING SKILLS PROGRAMME ON STUDENT LEADERSHIP AND INVOLVEMENT IN MEDICAL EDUCATION

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Peer-assisted learning (PAL) forms a major component of extracurricular support for students. Yet, formal training in teaching during medical school is scarce. Imperial College Medical Education Society is a student-led society providing PAL for students across London. The study assesses the impact of the 'Teaching Academy', a pilot training scheme, on the teaching skills of pre-clinical medical students and determine whether such programmes inspire interest in medical education and application to societal leadership responsibilities. The programme was advertised via email. Enrolled students completed a pre- and post-course questionnaire to assess baseline teaching experience and efficacy of the pilot scheme respectively. Five workshops were delivered over three months addressing various teaching skills. Participants practised teaching under the supervision of experienced students and clinicians. Of the 59 applicants, 16 were accepted. From the preliminary questionnaire, 81.3% (13) of students reported having previous teaching experience. However, 81.3% (13) had not received formal training on teaching. 14 completed the course and subsequently the post-course questionnaire. All students agreed or strongly agreed that their teaching skills have improved. This included maintaining audience engagement (12, 85.7%), making effective presentations (12, 85.7%) and giving constructive feedback (6, 42.9%). 64.3% (9) appreciated the personalised feedback and hands-on aspect of the course. 85.7% (12) agreed or strongly agreed that the course inspired interest in medical education. Over half of the cohort expressed interest in holding future committee positions and responsibilities to sustain the programme. Nurturing the talent of early-years medical students may improve teaching competency and promote involvement with future educational and leadership opportunities. For future cohorts, the team plans to deliver 'theory-based' sessions virtually to allow more time for hands-on teaching experience.

Technology adoption

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ARTIFICIAL INTELLIGENCE AND THE NHS: A QUALITATIVE EXPLORATION OF THE FACTORS INFLUENCING ADOPTION

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10.1136/leader-2020-FMLM.142

Background Artificial intelligence (AI) has the potential to improve healthcare and is likely to impact almost every specialty. However, there is limited research investigating the factors which influence the adoption of AI within a healthcare system.

Research Aims To use innovation theory to understand the barriers and facilitators which influence AI adoption in the National Health Service (NHS). To explore solutions to overcome these barriers, and examine these factors particularly within radiology, pathology and general practice.

Methodology 12 semi-structured, one-to-one interviews were conducted with key informants. Interview data was analysed using thematic analysis.

Findings A range of barriers and facilitators to the adoption of AI within the NHS were identified, including information technology (IT) infrastructure and language clarity. The factors influencing the adoption of AI were categorised into three themes: the NHS as a System, the People who will be adopting AI and the Technology itself. Several solutions to overcome the barriers were proposed by participants, including education and innovation champions.

Conclusion Education and champions should be explored as facilitators to the adoption of AI in the NHS. Clarity on information governance could support data sharing to develop AI products. Future research should explore the importance of IT infrastructure in supporting adoption, examine the terminology around AI and explore specialty-specific barriers to adoption in greater depth.

Leading innovation and improvement

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SEPARATING WOOD FROM THE TREES. ANALYSING REGIONAL VARIATION BY SYSTEMATIC COLLECTION AND ASSESSMENT OF PAPER FORMS USED IN NORTHERN IRELAND HEALTHCARE

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10.1136/leader-2020-FMLM.143

Encompass is a regional transformation introducing an electronic healthcare record across Health and Social Care in Northern Ireland (HSCNI).

This technological advance requires thorough understanding of all aspects of HSCNI. The build of encompass will be guided by clinical staff in the role of subject matter experts aligning diverse processes across trusts to one way of accessing care for all citizens.

Our project collected all paper forms used across HSCNI, this forms foundation for standardisation of future healthcare and resulted in collection of over 10,000 paper forms.

These forms were collected centrally, catalogued and documented onto a database. This database was populated using a 5 stage protocol for the purpose of collating, assessing, documenting, removing duplication and analysis. Forms collected exhibited evidence of significant duplication and variation. Dissemination of this learning will promote significant quality and efficiency improvement.

Initial stakeholder engagement took place prior to collection of forms in partnership with clinical staff, analysis by the encompass team took place including protocol design with regional clinical experts and staff training.

Final results from the form collection showed almost 4,000 unique forms, after de-duplication. This triggered a further project currently underway, cataloguing data elements from every form to allow a strategic method of standardisation.

The benefits of standardisation envisaged are increased efficiency, patient care and patient safety. Collating all paper forms was no small task and the mammoth effort undertaken by all cannot be understated.

Our experience shows that there is significant variation in many areas, different forms generated in different trusts by different clinicians generate significant variation across a small region. We encourage healthcare professionals to standardise as much as possible through personalised efforts like this to continually drive improvement.

Leading across systems and organisations

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CENTRALISING THE RENAL CANCER MULTI-DISCIPLINARY TEAM FOR EQUITABLE ACCESS TO SPECIALIST SERVICES

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10.1136/leader-2020-FMLM.144

Problem The multidisciplinary team meeting (MDT) provides a consensus and expert opinion. Traditionally each hospital has its own cancer MDT and refers on specialist centralised services. The following issues with this were raised:

1. Equal access to specialist opinions
2. A single renal surgeon providing the consensus opinion
3. Delays in the patient journey incurred by the referral process

Intervention A weekly regional MDT was established comprising of renal teams from each hospital in the West of Scotland as well as the specialists providing centralised services. Every renal cancer patient in the West of Scotland is discussed by a panel of specialists as well as local teams. A patient can be added directly to a waiting list for a centralised service.

Comparison The regional MDT was assessed in two ways.

A survey of MDT members highlighted the key advantages are: equality of access, a standardised approach across the region and real time liaison to specialists. The key disadvantage was the length of meeting as the number of cases discussed increased for all involved.

An analysis of the patient's journey before and after the intervention demonstrated a significant reduction in time from MDT to partial nephrectomy (a key centralised service) and no change in the time to communication of a decision.

Outcome The regional MDT ensures that each week every patient has the benefit of an expert consensus opinion and streamlines access to specialist services, including clinical trials. In addition, by its nature, the regional MDT has reduced variation in practice. It has increased the time commitment of individuals and we are looking at mechanisms to improve efficiency to offset this.

Learning Points in Leadership: In developing a regular team meeting across several NHS boards, buy in from local clinical representatives was vital to drive negotiation with local management.