Impact Each focus group had a single moderator and 7-9 participants. Two key questions were shared, and outcomes collated.

1. What resources do you have in your organisations to enable a compassionate approach to managing concerns regarding doctors?
2. What can be done collectively to enhance compassionate leadership?

Intervention Focus group suggested interventions to enhance compassionate approaches collectively yielded 135 responses categorised under 4key themes.

1. Visible leadership to influence cultures(n=42)
2. Reviewing Systems/processes to embed compassion(n=56)
3. Compassionate language in policies(n=11)
4. Supportive resources: education/training(n=26)

Involvement of stakeholders, such as patients, carers or family members:

All 71 key audience were NHS users as patients.

Key Messages NHSENW succeeded in demonstrating 6 key effective leadership outcomes achieved at this phase of the project.

1. Effectively transformed compassionate listening into demonstrable co–created, strategic system solutions, for compassionate actions fulfilling fundamentals of compassionate leadership1
2. Effectively laid the foundational elements of collective leadership through setting direction with clear vision, enabling alignment with values and commitment for prioritising/progressing compassionate leadership collectively as regional network of leaders (2,3).
3. Developed a kindness/compassionate pledge and effectively demonstrated how user views can be powerful for value alignment as guiding principles.
4. Compassionate leaders donâ€ ™t have all the answers and donâ€ ™t simply tell people what to do, instead they engage with the people they work with to find shared solutions to problems (3)
5. When a leader as NHSENW launches an initiative to realise the vision of 'Growing Compassion', it paves the way for other organisations/leaders to follow with peer support.
6. System leadership encourages leaders to embrace uncertainty and to get started with initiatives from where you are, with what you have even if whole path is not chartered

Lessons learnt Investments on qualitative approaches with additional moderator and Patient representation for future.

Measurement of improvement NHSENW succeeded to collectively translate 'compassionate listening to action' and the outcome was a series of co-created strategic system solutions developed in readiness for regional launch in November 2022.

1. Compassion/kindness pledge as a set of value aligned guiding principles.
2. Compassionate tool kit for supporting doctors/governance/HR teams
3. Education/training package for compassionate conversations in challenging situations when managing complex performance concerns by NHSR with NHSENW input.
4. Compassionate Policy updates with people focus more than process focus.
5. Prioritising compassionate leadership &Sharing good practice to spread compassionate ripple further
6. Onboarding support package for new International Medical Graduate Doctors awaited from HEENW.
7. NHSENW risk assessment template for objective assessment on thresholds for formal investigation to reduce bias/enable consistency/transparency shared.(4)
8. NHSENW investigation closure template updated to capture system/contributory factors/organisational learning to ensure a compassionate approach beyond human factors and shared.

Strategy for improvement All co-created strategic system solutions developed as outcome from focus groups is to be launched regionally at the RO/MD network event in November2022.

These outcomes from initial phase form the interventions for next phase of cycle. NHSENW will continue to monitor impact, through Quality Improvement methodologies including further focus groups in autumn2023, leaders interviews &next PDSA cycle (Plan-Do-See-Act).

28 ORGANISATIONAL STRATEGIES TO SUPPORT NHS STAFF IN RESPONSE TO THE COVID-19 PANDEMIC

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10.1136/leader-2023-FMLM.23

Context This case series aims to assess the organisational strategies utilised by two NHS trusts (trust A and B) in North West England in order to improve the well-being of their Healthcare workers (HW) during the time period from December 2019 to March 2021. In the context of existing clinical leadership theory, we investigated what organisational strategies leaders and managers in English hospitals can use to improve the well-being of HWs in response to the COVID-19 pandemic.

1. Establish what strategies are being used by trusts to improve the mental well–being of healthcare workers
2. Ascertain which risk factors are associated with poor mental health during the COVID–19 pandemic in NHS healthcare workers
3. Examine whether strategies can be designed using limited resources to meet the challenging mental health

Issue/Challenge A higher prevalence of mental health issues (MHI) such as depression, burnout, post-traumatic stress disorder (PTSD) and anxiety is observed during epidemics and pandemics. In May 2020, during the COVID-19 Pandemic, Mental health Illnesses (MHI) accounted for 28.3% of all sickness leave in the UK NHS. The highest sickness absence rate (SAR) in the United Kingdom (UK) was reported in the North West England (NWE) at 4.9%; with MHI being consistently responsible for sickness absence, accounting for 31.8% of all sickness leave in June 2020, placing a huge strain on limited resources and patient safety and care.

Assessment of issue and analysis of its causes

Following written, informed consent, semi-structured, 60 minute interviews were conducted via video-conferencing with six participants (clinical managers or directors) of two NHS Trusts in NWE. Interviews were recorded and transcribed verbatim. The transcripts were then read, and Coding was done using NVivo software in an iterative process which used a leadership framework oriented around the interview questions.

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We also conducted a retrospective data collection on the average monthly percentage of Full Time Equivalent (FTE) days lost to mental health issues from the trusts' databases between 1st December 2019 and 1st March 2021 in order to triangulate strategies impact on sickness absence rate.

Impact To date, there is no case study research on the strategies implemented in NHS trusts that address the consequences of the COVID-19 pandemic on HW's mental health and wellbeing which utilise absence data.

Intervention Trust A had a higher Sickness absence rate versus Trust B, despite the greater funding and larger wellbeing team utilised in Trust A. Understanding early on, via surveys, the needs of HW in Trust B, contributed to their effective response and target of resources. The practical support offered by Trust B may have acted as preventative and proactive measure for poor mental health. Trusts psychological support approach may have only benefitted HW in later stages of MHI, such as PTSD. Nevertheless, Trust B is a significantly smaller trust, with fewer replacements, consequently, HW may feel less comfortable or less able to take sickness absence.

The least engagement in wellbeing strategies was seen in both Trusts amongst Black And Minority Ethnic (BAME) groups. Raising concerns in Trust A and Trust B was aided with BAME 'listening events' and a 'BAME network' forum respectively. The latter formed part of the 'governance structure' of Trust B, ensuring that official reports were acted upon. Trust A also introduced 'outreach calls' for nursing staff off sick due to MHI to check in on them with referrals to the Greater Manchester resilience hub and did regular health checks for early prevention of unhealthy behavioural patterns.

Both Trusts highlighted the importance of measuring the efficacy of strategies implemented. However, Trust B reported that due to the 'fast-paced nature of the start of the pandemic, evaluation was not as important then. Contrarily, Trust A submits quarterly reports on engagement with services, outcomes and feedback as part of their service delivery which they are constantly amending.

Key Messages Both NHS trusts in NWE identified similar risk factors for developing mental health issues and reported similar challenges in implementing wellbeing initiatives. Organisational strategies were dependent on each trustâ€ ™s needs and outcomes. Our study suggests that practical support may be more effective for stress and fatigue management during the peaks of pandemics in contrast to psychological support which may be more suitable during recovery phases. Screening for psychological issues may highlight areas of support and may enhance engagement with services, particularly in vulnerable population groups (BAME). Ultimately, a whole-systems leadership approach involving the aforementioned systemic change to organisational culture is needed in order to meet the wellbeing needs of healthcare workers.

Lessons learnt An organisational, rather than individual, approach to re-building team cohesion should be preferred. Furthermore, the focus of interventions in both trusts was individual psychotherapy, with minimal exploration of organisational cultural factors. Even though practical support was seen as superior to psychological interventions in Trust B, both wellbeing strategies may help improve overworked occupational culture.

Self-care coping mechanisms were emphasised more during the peaks of the pandemic. Similarly, according to Avero et.al. 2003 wellbeing initiatives during the peaks of pandemics should help HW cope with stress and trauma, whereas during recovery phases of pandemics they should help with processing psychological trauma.

Identifying common manifestations such as unhealthy eating, smoking and alcohol consumption may be more effective than relying on HW self-reporting. Nevertheless, this system relies on open and honest conversations with HW.

34 SERVICE EVALUATION OF THE PAIN EDUCATIONAL RESOURCES AVAILABLE TO FOUNDATION DOCTORS AT A TERTIARY TRUST

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Context A service evaluation of the pain education available to junior doctors at an acute tertiary hospital in England. A project led by a junior doctor in collaboration with the trustâ€ ™s acute pain team. This project is aimed at leaders/healthcare professionals designing postgraduate training for junior doctors.

Issue/Challenge

- Anecdotal reports of low confidence by junior doctors around pain management in patients with pre–existing pain.
- Reports of prolonged hospital admission due to issues with pain management and opioid weaning
- Assessment of issue and analysis of its causes
- To fully appreciate the scope of the problem locally, a service evaluation was carried out in two steps:
- –Firstly, through an audit of all pain management resources available at the trust against the curriculum set out by Health Education England and the Faculty of Pain Management for foundation doctors
- –Then survey of foundation doctors at the Trust to assess the perceived level of confidence in managing the patient group and key problem areas

Results of the evaluation were shared with the medicine governance committee at the trust; gaining the views of the multidisciplinary specialists on different interventions that would help address the critical issues identified.

Impact Chronic pain is a global health challenge with a profound socioeconomic burden on healthcare systems. The number of patients with chronic pain admitted for inpatient care is rising and junior doctors manage these patients during their admission. Inadequate pain education among non-pain specialists has been highlighted as a barrier to effective pain management. This evaluation has been instrumental in championing change around the pain education of doctors locally. The interventions hope to address the inequity of care that these patients might experience.

Intervention Findings revealed a gap in education and resources for chronic pain. The local teaching focused on acute pain. Trust guidelines available were for postoperative pain and there were no pathways to seek expert advice for inpatients with chronic pain. Junior doctors demonstrated good awareness and use of trust guidelines on acute pain, however, there were variations in opioid prescribing practices, with some deviations from national best practice recommendations. Based on these findings, a multimodal intervention that addresses the gaps identified is being implemented:

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