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of their department, and none have had previous bad experiences with AI.

Key messages Regardless of the approach that is taken, those in leadership positions within ophthalmology departments must find a way to increase the time spent on digital health projects, as this will remove a significant barrier to the integration of new technologies, and the capacity that this creates.

The main perceived barriers to adoption of AI solutions in the departments were lack of time to investigate and implement solutions, concerns about the cost of setting up and maintaining AI as well as governance and patient safety concerns.

11 INVESTIGATING THE REASONS BEHIND CHRONICALLY LOW RATES OF RESULTS ENDORSEMENT WITHIN OXFORD UNIVERSITY HOSPITALS TRUST

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Introduction The World Health Organisation's Patient Safety Forward Programme identified a failure to follow-up on tests being critical to patient safety. Oxford University Hospitals' (OUH) Trust aim to tackle this via their endorsement system. Trust policy at OUH is that all requesters of diagnostic tests are required to endorse at least 90% of results within 7 days of them being issued. However, this has consistently not been achieved across multiple specialities at OUH. We found there were no official rules to mandate the policy and several serious incidents have been reported, where the untimely and/or lack of results endorsement has compromised patient safety. The current system is such that when a diagnostic test is requested, the result will go into the inbox of the requester and also the named consultant of the patient; where they can endorse the result.

Aims and objectives of the research project or activity We sought to identify a specialty with low endorsement rates and explore why their rates were so low and how we could help to improve this.

Method or approach We obtained detailed speciality-wide data regarding results endorsement and identified cardiology to have chronically low endorsement rates. We prepared a survey and sent it out to all foundation doctors within the trust, and clinical staff working in cardiology at the John Radcliffe (JR) Hospital to gauge their opinions on endorsement and any suggestions on how we could help them increase their endorsement rates.

Currently, only the requester and the named consultant can endorse results. Following the survey results, we worked with the digital team to add an 'endorse' button onto the electronic patient records that anyone can press once they have reviewed and actioned patient results. We arranged a meeting with staff in the cardiology wards at the JR and showed them how to add the endorse button, as well as educating them on the importance of results endorsement.

Findings During the month of October 2023 (before our intervention), endorsement rates within cardiology were 58%. During the month of November 2023 (after our intervention), endorsement rates were 61%. We obtained further opinions from cardiology staff and discovered that clinical pressures regularly prevented them from endorsing results. As there is an audit trail associated with results endorsement, there is a fear of legal responsibility when putting one's name to a result; more so when there are clinical pressures affecting an individual's willingness to confidently endorse a result. Furthermore, cardiology staff stated that although anyone could now easily endorse results, there was no obvious clinical benefit in doing so, thus they didn't feel motivated to take the time to properly endorse results.

Key messages We discovered that not only is further education on results endorsement required, but our project also highlights the importance of ensuring staff feel comfortable enough to endorse results. There is an apparent belief that endorsement has no clinical benefit and puts you in a potentially legally compromised position. We are working with our stakeholders to try and improve communication regarding the benefits of results endorsement and have also received input from the legal team that there is a 'no-blame' culture within the Trust, thus individuals shouldn't feel worried about endorsing results. Overall, this project has highlighted that making improvements to the computer system only slightly increases endorsement rates. There should be work put into the human factors, exploring people's apprehensions and how they can be alleviated.

12 HOW CAN LEADERSHIP IN NHS HOSPITALS BE IMPROVED TO ENSURE BETTER QUALITY OF CARE FOR PATIENTS?

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Introduction The inspiration for this literature review came from the Francis report (2013) on the failings of the Mid Staffordshire NHS trust in delivering high quality of care to patients. The hospital's non-clinical managers, doctors and nurses with leadership positions, all prioritised the 4-hour waiting-time target over safe and good quality practice (Allen and Dennis, 2010). Consequently, one of the main recommendations from this inquiry was to improve the leadership within the Trust. It argued that leadership is essential; delivery of healthcare must be patient centred; and that the responsibility of leadership must be shared across all levels within a hospital, from its board members all the way down to the frontline staff working on wards (Kings Fund Commission, 2013). Improving leadership was encouraged for hospitals across the country and the Mid Staffordshire Trust scandal became a spotlight for demonstrating just how important leadership is for delivering a high quality service.

Aims and objectives of the research project or activity During the initial scoping of literature on leadership in health, it is noticeable that there is abundant research indicating that leadership is important to healthcare delivery, but limited research was available on how this leadership can be improved to better the quality of care delivered to patients. This literature review therefore aimed to find strategies that can be implemented in hospitals to improve current leadership of doctors and nurses working in NHS hospitals. The research question that guided this review was posed as: 'How can leadership be improved in NHS hospitals to ensure better quality of care for patients?'. Themes to categorise the results were identified using the World Health Organisation's framework for leadership development in health (2009).

Method or approach The search was performed in the Medline, CINAHL and EMBASE databases for the time period of 2013–2021. Themes to categorise the results were identified using the World Health Organisation's framework for leadership development in health (WHO, 2009). The framework provided four key factors that are required to improve leadership in health systems: (1) adequate number of managers, (2) appropriate competencies, (3) functional support systems and (4) enabling a working environment. Papers had to be peer-reviewed articles published after 2013, which yielded a total of 564 possible documents for review. Inclusion criteria: (1) Records must be relevant to UK NHS hospitals; (2) Population target must be doctors and nurses; (3) Intervention must look at how leadership is developed; and (4) Outcomes must measure quality of care.

Findings 564 articles were initially found. After using the inclusion criteria and screening the articles, 11 articles were finally included in the literature review to answer the research question. 6 studies concluded that we need to have more doctors and nurses in leadership roles and appropriate competencies such as effective communication and teamwork must be developed to improve leadership potential and skill (Mckee et al, 2013) (Dewar, 2014) (Miani et al, 2013). 2 papers proposed that hospitals require functional support systems. 8 papers called for an enabling working environment such as having incentives in place for staff to develop leadership (Phillips, 2013). The Francis report (2013) found that fear over whistleblowing was seen as issue that prevented many staff from raising concerns over the quality of care provided to patients in the in the Mid Staffordshire scandal. Failure of clinical leaders to set examples on high quality practise and a lack of trust in them by other colleagues meant that the quality of care given to patients diminished. When minor incidents and wrongdoings happen constantly, overtime they become the new norm and that reduces the standard of care provided to patients (Mastracci, 2016).

Key messages Effective clinical leadership has been linked to a better overall health system performance (Daly et al., 2014), and in particular it relates to providing a high quality of care which is why this topic is so important (Sfantou et al., 2017). Future doctors and nurses should consider developing their leadership skills and ability. NHS organisations should also encourage their staff to develop such skills and allow more doctors and nurses to become clinical leaders, to overall better the quality of care provided to patients. The methodology I used was systematic and one of the key strengths of this literature review as it kept a focus on NHS England Trusts, which other systematic reviews don't do. However, the lack of research in this field must encourage us to pursue more quantitative based studies on leadership in the NHS and how it can help us better patient outcomes.

13 DOCTORS' PERCEPTIONS OF DOCTOR-MANAGERS AND ITS IMPACT ON MANAGEMENT CAREER ASPIRATIONS

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Introduction There is growing evidence that doctors may make for superior executive managers compared to their non-medically trained counterparts according to financial and staff performance, and patient outcomes. This is reflected as 66% of the top 100 global hospitals are doctor-led. However, only 10% of NHS Trusts are currently doctor-managed. Examining this disparity revealed several barriers preventing doctors' entry into such roles, including the lack of a defined pathway and job insecurity. We focussed on the sparsely researched area of the effect of doctors' perceptions on their intentions to become managers. Our research identifies doctors' perceptions of healthcare leadership across all levels of medical training and sheds light on the complex dynamics driving their perceptions. Ultimately, we aimed to create interventions to enable more potential doctor-managers to enter leadership roles. This was performed through semi-structured interviews with secondary care doctors at various stages in their training and professional development.

Aims and objectives of the research project or activity We conducted a literature review aiming to understand reasons as to how and why perceptions influence doctors entering managerial roles. Our subsequent research focussed on the transition of doctors to doctor-manager roles within secondary care in the NHS, emphasising doctors' perceptions surrounding this shift. Our aim was to explore the attitudes of doctors towards doctor-managers and how they influence, if at all, their own transitions.

Thus, the main research question addressed doctors' perceptions of NHS Trust Executives at all levels of medical training, examining the factors influencing these views, and their role as potential barriers or facilitators to managerial positions. This was with the aim of:

- Understanding what the perceptions are
- Understanding how such perceptions affect doctors entering managerial roles in the NHS
- Identifying the drivers behind these perceptions
- Identifying differences across levels training in such perceptions
- Creating and trialling interventions to address drivers of perceptions

Method or approach Our research employed a three-stage methodology, involving sample selection, semi-structured interviews (SSIs) and thematic analysis.

The decision to use 29 SSIs, spanning all levels of medical training, stemmed from limited prior research on perceptions hindering doctors from entering managerial roles, allowing flexibility to explore new insights whilst maintaining a structured framework. Snowball sampling was utilised for participant recruitment, to effectively target senior executives in a specialised population. Diverse initial informants mitigated community bias. Interviews, conducted virtually, incorporated open and closed questions, fostering a free-flowing conversation for deeper insights. Pilot interviews informed iterative question refinement.

Thematic analysis, employing Braun and Clarke's process, revealed perceptions and drivers. These perceptions and drivers were then analysed and compared to existing literature to derive novel insights. (The study contributes to understanding doctors' career pathways and provides practical insights for addressing managerial role perceptions in the medical profession.)

Findings From our data, we were able to identify interesting and novel findings.

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