TSDFT was in its infancy and was largely unstructured, allowing space for trainees to redesign, seek mentorship and explore opportunities.

Our intervention included informally seeking mentorship from a deputy medical director at TSDFT, who was enthusiastic about promoting trainee leadership development and experienced in quality improvement. We met fortnightly for goal setting, collaboration and discussion about challenges within the field. Other experiences and achievements were mapped to the 'Medical Leadership Competency Framework'³ facilitating reflection and inquiry about valuable elements of the program and highlighting areas where experience was lacking; allowing focused search for opportunities.

Outcomes included TSDFT academic trainees being increasingly positive about the program, gaining structured approach to their academic time and improved productivity and accountability to peers and mentor. Trainees also described better understanding of local healthcare management and have led on projects aligned to the Trust's priorities.

Supporting trainees with interest in leadership and management remains challenging; unlike clinical competencies tangible demonstration of leadership development is difficult. AFPs in leadership and management provide a unique opportunity to support development of individuals with aptitude or interest, with reciprocal benefits for individuals and organisations. We recommend organisational leaders take responsibility for fostering environments where any trainee can develop leadership and management skills; current leaders should consider mentorship as part of their role as a clinical leader.

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Innovation in community care

63 IMPROVEMENTS IN PATIENT CARE IN A COMMUNITY BASED DIABETES SERVICE DRIVEN BY A BESPOKE BUSINESS INTELLIGENCE PROGRAMME

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Diabetes Care for You (DCFY) is a multi-professional specialist community service for adults living with Type 1 and Type 2 diabetes in Brighton, Hove/High Weald, Lewes and Havens CCGs. There are 1195 people with Type 1 and 3390 with Type 2 currently.

The DCFY team were unable to access real-time population level data, in a user friendly way. Meaning an increasing proportion of time was dedicated to generating information. This inability meant that targets, such as referral to treatment waiting times (RTT) could not be predicted.

A bespoke Power (BI) suite of reports was developed. The technology provides up to date data allowing cohorts to be viewed in an easy to read form. It compiles patient data using coding and displays chosen metrics that can be easily changed to generate patient lists.

This technology has allowed the identification of discrete patient cohorts and identifies when appointments need to be booked or interventions need to be discussed. It identified 277 type 2 'poorly controlled' (HbA1c>80) patients. Currently 63 of those patients do not have a booked appointment and 12 are not on insulin. The technology has led to improved outcomes because previously the quick collation of this data would not have been possible.

RTT data retrieval has become more time efficient and streamlined, saving 1.5 days per month of Managerial time. RTT compliance has risen from an average of 87.3% during June, July and August in 2017 to an expected 95.9% during the same months in 2018.

Leading innovation and improvement

64 CARE REDESIGN – A MULTI-DISCIPLINARY, MULTI-FACETED SYSTEMS APPROACH TO REDESIGNING CARE PATHWAYS

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10.1136/leader-2018-FMLM.62

The Antenatal Day Assessment Unit (ADU), the A and E of maternity services, in a central London tertiary hospital, was inspected and reported as having inadequate capacity and poor patient and staff experience. It offers an open-access, 24 hour walk-in service for urgent/emergency care.

We undertook an integrated, trust-wide care redesign programme (CRP) to transform the pathways and patient flow. Our team included consultant obstetricians, specialist trainees, midwives, a clinical coder/analyst, a change agent and maternity service manager, with support from the trust medical director and an international expert with Harvard Business School experience. The CRP consisted of structured sessions including principles of systems thinking, unwarranted variation, changing culture and leading transformational change. There was protected coaching, team-time and web-based resources. Key metrics were agreed and measured including time from attendance to assessment of the fetal heart, and measures of patient satisfaction.

A value proposition was co-produced, enabling us to focus our transformational efforts. Key stakeholders were consulted regarding potential new names for the unit better reflecting its function. Unscheduled care pathways were characterised, optimised and separated from scheduled care pathways. Changes were made to reduce waste (any process that did not directly add value to women).

A systems-wide approach has resulted in a sustained improvement in key metrics. The renaming of ADU to the Maternity Assessment Unit and the value proposition has enabled the team to implement change in a logical manner and visual representation of data has empowered frontline staff to engage in the transformational experiments. This

required senior clinical leadership that is committed, visible and facilitative. The support provided by the medical director and trust executive team was crucial to enable the team to experiment and apply the principles of reducing unwarranted variation.

65 INITIATING, IMPLEMENTING AND MAINTAINING A COMPREHENSIVE EDUCATIONAL PROGRAM FOR DONOR CLINICIANS WITHIN NHS BLOOD AND TRANSPLANT

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10.1136/leader-2018-FMLM.63

Background NHS Blood and Transplant (NHSBT) is responsible for the efficient, safe and reliable supply of blood in England. Within NHSBT, the Clinical Support Team (CST), with Donor Consultants, SAS Doctors and Senior Nurse Practitioners based at different sites, are responsible for the care of blood donors. Continuing professional development (CPD) is vital in this regard. Educational events were however sporadic and not centrally managed. An educational quality improvement project was therefore initiated in 2017. Existing Information Technology (IT) was used to deliver a high quality, diverse, fit-for-purpose and cost-effective educational program.

Method An 'Assess-Plan-Do-Review' framework was followed with an initial 'scoping' meeting to identify the educational needs, promoting a culture of collective ownership. A dedicated teleconference line was allocated and all educational resources were saved in an accessible platform. Sessions were delivered by invited speakers, maximum 1 hour in length, on different days of the week, 4–6 weekly, covering a wide range of topics. A SurveyMonkey questionnaire was circulated in November 2017 to evaluate this initiative.

Results Twenty successful educational sessions have been delivered so far, covering a range of topics. Operational colleagues have also joined in some sessions promoting shared learning and inter-professional education. With an 83% response rate to the questionnaire, it confirmed that the program's structure was appropriate and addressed educational needs successfully. Suggestions for improvement were captured, including the use of Skype and establishing a Journal Club.

Conclusion It resulted in a positive, collaborative climate and an enthusiastic, participatory learning environment. Reliable IT facilities are vital for successful delivery of such a program to geographically dispersed teams. Commitment and constant review is necessary to ensure the educational program remains fit-for-purpose.

66 IMPROVING INFORMATION PROVISION IN DELIRIUM CARE

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10.1136/leader-2018-FMLM.64

Background Delirium is a common hospital presentation among the elderly population. Chronicity of this condition necessitates that relatives and carers have better access to

information. Patient information leaflets offer a simple and cost-effective solution to managing patient education.

Aim(s)/objectives To improve leaflet distribution in Plan, Do, Study, Act (PDSA) cycle 1 and to improve information, aesthetics and educational quality of the current delirium information leaflet in PDSA cycle 2.

Methods PDSA cycle 1 focused on leading improvement in leaflet distribution. Interventions included putting up posters around the ward, introducing the project in team meetings, via emails and moving the leaflet stand to a more visible location. In PDSA cycle 2, baseline data on the quality of the current leaflet was gathered using a questionnaire. A pilot leaflet was developed based on the feedback. The pilot leaflet was surveyed again for quality assessment and to gain further feedback.

Results In PDSA cycle 1, delirium leaflet distribution for weeks 1–3 was 40%, 0% and 20% respectively. Following an implementation of intervention measures, it increased to 110%, 120% and 100% in weeks 4–6 respectively. In PDSA cycle 2, mean 'Aesthetic Quality' score improved from 5.14 to 8.71 ($p < 0.00001$), 'Quality of Information' from 5.86 to 8.94 ($p < 0.00001$) and 'User Knowledge Rating' from 5.43 to 9 ($p = 0.00003$).

Conclusion Overall, we achieved an increase in leaflet distribution and succeeded in developing a new and improved pilot leaflet. Due to the generalisable nature of this quality improvement project, we believe that the framework can be used elsewhere to improve health information management and provision.

Quality improvement

67 IMPROVING EFFICIENCY OF CARE FOR ADULT TYPE 2 DIABETIC PATIENTS UNDER SECONDARY CARE

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This quality improvement paper aimed to improve the efficiency of care for type 2 diabetes mellitus patients. This was done by analysing why patients are not being discharged from hospital diabetic care back to the community whilst creating a novel discharge criterion to help standardise the process. In England over 9% of the population have been diagnosed with diabetes; with £13 billion a year being spent on treatment. In the current financial climate, we must ensure that the vast resources being spent are spent as efficiently as possible.

As medical students at the Lewisham and Greenwich trust we found a lack of a discharge criterion made it difficult to discharge patients from hospital care back to the community. Therefore, to improve quality of care and bring cost savings to the department, we aimed to define a clear discharge criterion to de-escalate patients to primary/community care, maintaining optimum care, and increasing the number of discharged patients by 10% over a 12 month period.

We performed two PDSA cycles on 501 randomly selected patients and found an extra 11.27% of patients could be de-escalated down to community care (from secondary) using our criteria. This quality improvement project could optimise and