

Patient flow

88 THE BRADFORD DIAGNOSTIC VIRTUAL WARD: LEARNING FROM OUR FIRST YEAR

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The Diagnostic Virtual Ward is a cross-specialty initiative which aims to support the earlier discharge of a low-risk cohort of inpatients within Bradford Teaching Hospitals NHS Foundation Trust. It is designed for inpatients who are clinically stable but who require at least one investigation in an urgent timescale. The service offers an opportunity to shift their care from hospital to home.

We held discussions with key stakeholders whilst designing this service. These included staff from medical and surgical specialties, radiology, endoscopy, and cardiac investigations. A coordinator was recruited. The service was initially offered as a pilot on one ward in September 2016 and subsequently spread to other areas. Ward staff contact the coordinator to make a new referral. She visits the ward, checks patient suitability and explains the service to the patient prior to discharge. The coordinator then liaises with the relevant investigation department(s) and contacts the patient. She tracks the patient's progress and, upon completion of their investigation(s), forwards the result(s) to their consultant.

During its first year, 963 patients were referred to the Bradford Diagnostic Virtual Ward for 1103 planned tests. 541 patients were female. The service was used by 19 specialties with the largest usage seen in general surgery, urology and stroke medicine. 83% of patients progressed through the pathway as intended. 4.9% of patients were readmitted whilst on the pathway. 1.7% of patients had problems such as claustrophobia at their test requiring rescheduling. 10.5% of patients did not attend their test as initially planned. 52% of test results were abnormal but only 2.3% required same-day action. There were no reported adverse events.

This initiative has saved the trust an estimated 1960 bed days in its first year, representing a minimum potential net saving of £3 48 000. Our main challenges are improving staff awareness of the service, ensuring a robust governance structure and fully integrating this service with the recently implemented electronic patient record.

Orthopaedic consent

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Consent is a vital two way process between clinician and patient, and done well, ensures that patients are able to make informed decisions about their care. A quality improvement

project was designed to improve consenting at Central Middlesex Hospital.

A 6 week prospective audit of the consent taken for Total Knee Replacements (TKRs) and Knee Arthroscopies (KA) was performed. The consent forms for these procedures were analysed for the risks documented, the legibility and whether alternatives to surgery were discussed and documented. In total 15 KAs and 21TKRs were reviewed. The risks documented were compared to a standard taken from www.OrthoConsent.com (OrthoConsent) – a website endorsed by the British Orthopaedic Association. From this website, 12 risks were identified for TKRs, and 7 for KAs. Our data identified that on average, just over half of the risks for TKRs were consented (53%), and slightly more than two thirds consented for KAs (68%). The legibility of the hand-written forms was graded on a scale of 1; illegible, 2; legible, and 3; printed, with majority being graded as 2. No alternatives to surgery were discussed during consent.

The intervention used by our group was to print consent forms from OrthoConsent and use them alongside the hand-written forms. We re-audited for 6 weeks. The information is provided on a printed form, with alternatives to surgery included, the results of the re-audit showed 100% of the risks being documented, all consent forms being printed and legible (level 3 on the scale), and alternatives being discussed.

We demonstrated leadership skills in identifying a problem, investigating it and providing a solution to an important problem: consent. The results of our project have been communicated to members of our Trust and department with a view to implementing this to the wider practice.

Leadership and management development for training surgeons

90 UROLOGY SPECIALIST REGISTRAR LEADING THE CHANGE FOR POST-TRANSURETHRAL RESECTION OF PROSTATE (TURP) OPERATION FOLLOW-UP

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Current Post-TURP follow up protocol is for patients to attend hospital to provide urinary tests and complete a symptom questionnaire. The evidence based practice information is limited and my research to clarify this showed the questionnaire is the primary tool for follow up. Clinic attendance is a drain on staff time, local resource for urinary tests and associated higher cost to NHS but also a burden for patients as the expense of travel, time waiting for tests and interrupting their working/social activity. As such a change towards telephone clinics would potentially benefit all.

Follow up clinics were amended in a step wise fashion to prevent confusion of wholesale changes, initially patients would attend clinics as usual but only undergo questionnaire assessment. This was then advanced to telephone clinics with the questionnaire once this practice became standard culture.

The University of Birmingham Surgical Leadership programme provided an education in how to effect change. This