

Poster

Leading Innovation and Improvement

1 ESTABLISHING THE EVIDENCE BASE FOR 'MULTIPLE SITE SINGLE SERVICE' (MSSS) MODELS OF CARE

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Background In England plans for service reconfiguration increasingly include options for clinical services which are delivered across more than one clinical site, often in differing geographical locations or towns. The rationale for such models include the difficult and often conflicting balance between exacerbating inequalities in access to clinical services for patients whilst at the same time trying to improve quality and outcomes through consolidation.

Aim The East Midlands Clinical Senate in partnership with Public Health England (PHE) established a proactive work-stream to review the clinical evidence for 'multiple site, single service models of care' (MSSS) to support clinical senates, commissioners and providers of services better assess the evidence base for these types of models of care.

Methods Systematic review (SR) undertaken. Framework developed to Support Clinical Senates through qualitative data collection and consultation with national and local clinical senate meetings to consider the experience of MSSS models and where they have worked successfully to improve outcomes.

Results SR identified 18 papers for inclusion. Evidence on this topic was largely service-specific and heterogeneous in study design and outcomes. We found evidence of 10 key enablers and barriers to implementation of MSSS models. There was no universal definition for MSSS models in the literature, but shared characteristics were identified which enabled the development of a descriptive framework. Mortality was the most frequently reported outcome and no study reported increased mortality as a result of service change. 4 studies reported on patient experience related to service change, with some evidence of improvement in patient satisfaction with care delivered via a MSSS model

Conclusion Using the systematic review findings and the qualitative feedback, a clinical outcomes based framework has been developed to utilise when reviewing these types of models of care.

2 THE CANCER TAPESTRY

Andrew Crummy, Gillian Hart, Ioanna Nixon, Rodney Mountain. UK

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Cancer is a common disease of our era. The diagnosis can be devastating and therapies can have a high morbidity profile. However, treatments have evolved and discussion on quality of life issues, 'what matters to me' at every step of the cancer journey and survivorship with and beyond cancer are very important topics. Raising public awareness on such a common disease, discussing treatment and celebrating survivorship is key. Art can be the vehicle to initiate and promote these conversations. We present 'The Cancer Tapestry', a global piece of work led by the well known artist Andrew Crummy, a cancer survivor who designed The Great Tapestry of Scotland with the support of an oncologist and a surgeon. Our aim is like The Great Tapestry Of Scotland to involve at the very least 1000 volunteer stitchers, this time telling cancer stories 'stitch by stitch'.

The Cancer Tapestry project was launched on the 4th February 2019 at the Scottish Parliament with The Health Minister putting in the first stitch. The Cancer Tapestry is starting to create new partnerships between patients, families, clinicians and senior leaders, raising public awareness of cancer.

Within a short period of time the work done on the initial tapestry creations have been shared on social media and are starting to initiate a much wider level of interest in the project.

The tapestry will initiate a patient centered conversation throughout the country and will allow patients, carers, health-care workers and researchers to contribute stories related to their lived experience that surrounds cancer, cancer therapy, resilience and survivorship. It will be exhibited in galleries, hospitals and public areas and act as an educational tool.

3 SAFE TIMELY PERSONE CENTERD CARE – STEP

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Our organisation noted a reduction in performance in our patient experience survey Results and realised that our clinical governance framework needed to be refreshed and refocus the organisation towards patient centred care. Projects and work that were planned or already underway were mapped back to the framework, which we called STEP- Safe, Timely Person Effective Person centred care. Existing scorecards, polices and procedures were changed. Position descriptions, onboarding processes and performance appraisals were all rewritten to ensure our staff understood the elements of our new clinical governance framework. STEP was the result of our five clinical governance domains; leadership and culture, consumer

participation, risk management, clinical practice and our workforce. Early projects that were initiated under STEP included the development of a 'Fasting app' to prevent multiple episodes of fasting following cancellation of surgery by providing visibility on the elective surgery booking list. (Safe/Timely/Risk Management). Other initiatives included a next of kin texting initiative to update families on patient progress (Patient centred/Consumer Partnerships), implementation of multidisciplinary ward governance rounds (Effective/Clinical Practice) and participation in an online patient feedback platform (Patient centred/Consumer Partnerships). Our preexisting Safety Culture Program was 'rolled in' to our Clinical Governance Framework (Safe/Leadership and Culture). We believe this approach 'personalises' clinical governance and assists front line care givers and consumers in understanding how our organisation monitors and improves the care we provide, ensuring it is safe, timely effective and person centred.

Developing Effective Leaders

4 'SUMMITS' PROGRAMME – DEVELOPING JUNIOR LEADERSHIP IN SPECIALIZED HOSPITALS IN 'CLALIT', ISRAEL

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'Summits' is a unique programme for training next generation leadership in six specializing and relatively small hospitals in Israel, owned and operated by 'CLALIT' – the largest HMO in Israel.

The challenge was to build a training programme that would address the unique situation and culture of each hospital as well as the culture 'CLALIT', but also to create a common baseline of leadership skills and to develop them as an inter-hospital quality group.

The programme, based on the PBL method, had three dimensions: self-consciousness, better familiarization with the hospital and the CLALIT, and the interface between the different professions in these hospitals, as well as between the hospitals.

Each hospital selected a team of five participants from different professions who already demonstrated leadership skills, as well as a small group of mentors. Each team conducted two projects: learning about their hospital and introducing it to the other groups; identifying together with the hospital's Director General an important challenge and to come up with ways to address it.

The results were very encouraging. It was found that the PBL substantially increased the motivation and involvement of the participants, as well as their willingness to exercise leadership, and take responsibility and ownership of projects in the hospital. They also felt empowered and appreciated. In the long run, it should help preventing burn-out. The participants from each hospital developed a group mentality; some have already been nominated to their first management positions. The success of the first pilot led to the continuation of this training programme.

Leadership training by making people from different professions in the hospital joining hands and collaborate on real

challenges is a winning methodology. It not only contributes to the individuals who took part, but also improves the organizational ecosystem of the hospitals.

5 EVALUATION OF LEADERSHIP AND MANAGEMENT TRAINING PROGRAMMES FOR FOUNDATION DOCTORS

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10.1136/leader-2019-FMLM.5

Aim This study explored formal leadership and management (LM) training available to new Foundation Year 1 (FY1) doctors at South Tees Hospitals NHS Foundation Trust (STEEs) and compared it nationally. LM training is a topical field: FY1s feel unprepared for the LM challenges of practice; this contributes to anxiety and burnout, and increased patient safety incidents; and poor LM skills lead to poor patient outcomes. Patient safety, therefore, is at the core of this study.

Methods Since 2016 STEEs has incorporated LM training within FY1 Induction/Shadowing. Instigated by a STEEs FY2, and in a partnership between STEEs' Education Directorate and a Registered Apprenticeship Training provider, a FY1 LM apprenticeship programme, Foundation Leadership and Management (FLM), was piloted from December 2017. FY1s were surveyed anonymously, but individually tracked, during FLM. Further work is underway, including an additional 5 trusts being surveyed, to ascertain what other FY1 LM programmes are available, and the potential for dissemination and adoption.

Results With regards to self-rated preparedness for LM challenges, the results (n=164) show that: 40% feel prepared; 27% feel their undergraduate curriculum adequately prepared them; and 21% feel confident as a leader and manager. Those enrolled on FLM have shown significant increases in their self-rated scores. Additionally, research so far reveals local initiatives of varying content, delivery, and reach. There is yet to be a standardised, regional or national FY1 LM programme.

Conclusions Our research shows the feasibility of a FY1 leadership apprenticeship as a sustainable programme with positive impact on FY1s' LM preparedness. LM apprenticeships can be disseminated; two additional trusts adopted FLM in August 2019. Research into FY1 LM programme availability in the UK will offer the potential to change how FY1 LM training is delivered at a national level through the identification and promotion of best practice.

6 PEER TO PEER LEADERSHIP TEACHING FOR FOUNDATION DOCTORS

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Introduction Foundation doctors often say they feel intimidated by the idea of 'leadership' and have received little teaching on the subject. We planned to address this using peer to peer teaching. This method has been shown previously to