

Results Those on the FLM Apprenticeship showed greater self-rated preparedness for the LM challenges of practice when compared to those not on the Apprenticeship. Participants' first BRS in October 2018 was taken as a baseline and compared with their last BRS in January or March 2019. Increases in BRS were observed in over 70% of those on the FLM Apprenticeship compared to decreases in over 70% of those not on the Apprenticeship.

Conclusions LM programmes such as FLM can increase FY1s' self-rated LM preparedness and resilience. Apprenticeships offer an opportunity to establish locally deliverable LM programmes which holistically benefit staff in a resource constrained and challenging environment.

91 SYSTEMS LEADERSHIP LESSONS FROM PLANNING FOR WINTER PRESSURES

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Aims Unprecedented winter pressures in 2017–18 led to cancellations of elective activity across the NHS and deteriorating population outcomes. East Midlands Clinical Senate undertook a review of the local planning processes to manage periods of increased demand

Methods A two-stage approach was adopted:

- Literature review of national guidance
- Interviews with four local organisations

Conclusion 25 papers were identified with guidance falling within 8 key themes: patient flow (n=13), communication and collaboration (13), demand (13), system capacity (12), funding (6), planning (6), patient safety (3) and staff training (3)

The interviews revealed that despite similar system and operational challenges, clinical solutions are not being shared between commissioners and providers at scale

More collaborative systems leadership approaches from commissioners during winter 2018–19 resulted in improved outcomes across the system

The ambulance service is uniquely placed as a provider which interacts daily across local systems and with providers. This enables operational and clinical relationships to be developed and there was evidence of how a strategic approach to learning and responding to this insight had enabled better performance and outcomes following the winter of 2017–18

The importance of looking after workforce and creating the best possible conditions for staff to do their best for patients was highlighted

Recommendations Better sharing of data and practices across the region

Systems embrace and develop innovative ways of working to facilitate holistic care

Commissioners should consider acting more as facilitators (enable change to occur and issues to be tackled) rather than regulators (seeking assurances on what has already happened)

Develop better relationships with ambulance services to ensure practices are robust and standardised

Improvements in rotas and increased investment in staff (both in terms of staffing numbers and improved skillset of each staff member)

92 TELEDERMATOLOGY: AN INNOVATIVE APPROACH TO MANAGE SKIN CONDITIONS IN PRIMARY CARE

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Teledermatology is a newly growing service delivering dermatologic care, covering the entire field of dermatology, ranging from initial diagnosis to treatment and management. Teledermatology involves the use of medical photography to examine the skin of a patient together with the relevant history to diagnose dermatological conditions. Images are sent electronically to the dermatologist and in most cases receive a response within 48 hours. GP practices have started making diagnostic agreements with GP's with a special interest in Dermatology. Teledermatology gives the opportunity for the majority of patients to be treated by their own GP/Primary care, following a suitable management plan suggested by the GP with a special interest in Dermatology, but without having to attend hospital. By reducing the number of dermatology referrals to secondary care, Teledermatology can also help address the demand for dermatology care in hospitals. Teledermatology has shown to optimize resources, provide quick and efficient care as well as reducing the number of referrals to secondary care. It is a service that should be achieved by all primary care physicians. Teledermatology has the potential to permanently change the way that doctors manage their workflow and provide patient care.

93 INNOVATING IN CHILDREN'S URGENT CARE

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Aim The number of emergency department attendances by children and young (CYP) is on the rise. However, 90% of medical patients are discharged after initial assessment. The Ambulatory Care Experience (ACE) service is a new model for urgent care for CYP. The primary aim of the team is to provide child and family centred quality acute care at the right time and in the right place, ideally at home. The service provides an alternative to a hospital referral or admission for CYP.

ACE Intervention

1. Paediatric consultants take clinical responsibility from point of referral. Subsequently, CYP receive up to 5 days of home observation, delivered by a specially trained band 6 nurse.
2. Development of the service has required a system wide, shared ambulatory care vision. It was designed with families

by a multidisciplinary team including doctors, nurses, educators and managers. Best available evidence, national guidance and local clinical agreement were used to design and implement the service.

- In order to deliver the service a bespoke training package for nurses was developed which included the development of robust governance processes covering clinical and non-clinical interactions.
- Four separate work-streams are led and managed to deliver the service: implementation, training and competence, pathways and clinical governance.

Results Dec 2017- June 2019

83% of patients referred to the service have been managed entirely in the community. There has been 100% positive feedback and no adverse events.

Conclusion ACE is the result of system wide collaboration. The service provides specialist CYP and family centered acute care at home, consistent with the NHS Long Term Plan. It has been designed for adaptation and replication across the NHS. It is a good example of the healthcare leadership model and an innovative way of working, ensuring we can cater for the healthcare needs of our current and future population.

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DEVELOPING TOMORROWS LEADERS: TRAINEE LEADERSHIP ROLES

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Background The GMC has set out leadership and management responsibilities for all doctors,¹ however opportunities for trainees to gain exposure to these skills are not widespread, as post graduate training is predominantly clinical. An emerging way for trainees to gain these skills is by way of trainee leadership roles.

Discussion In an anaesthetic and critical care department there is opportunity for trainees to take on trainee leadership roles. There is a trainee leadership structure for senior trainees within the department mirroring many consultant roles (service lead/clinical director, governance, education, wellbeing, etc.). Candidates are selected by interview for 6-month posts. The programme began with a single trainee leader but has now expanded to 9 roles. The benefits to the department and ultimately patients have become more apparent as the structure has evolved, demonstrated by various improvements. Concerns raised by trainees via the trainee leads empowers them to design solutions. As the structure has evolved, the problem-solving capacity of the structure has improved such that problems are often presented to the consultant department leaders with sensible and practical solutions. Some issues like trainees missing training time are now entirely managed within the trainee leadership setup with regular reports to department leaders.

Furthermore, the benefits for the individual trainee are also significant for developing problem-solving, collaborative-working, communication and leadership skills.

Conclusion Engaged trainees can be enthusiastic and powerful agents for change when empowered and can improve patient care. Having a trainee leadership structure within a department allows trainees to develop into tomorrow's leaders.

REFERENCES

- Leadership and management for all doctors. GMC, 2012. Available at: https://www.gmc-uk.org/-/media/documents/leadership-and-management-for-all-doctors-english-1015_pdf-48903400.pdf(accessed 24/8/2019).

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COMPLEXITY SCIENCE IN CLINICAL ORTHOPAEDIC PRACTICE – IMPLICATIONS FOR ALL HEALTHCARE STAKEHOLDERS

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Complexity principles, highlighting the importance of interaction of agents, system history, start point and the potential for emergent events, may provide a better medical model. Our observation was of escalating clinical complexity, ie the interaction between the severity of primary condition and general status. We sought to quantify this.

Patients, methodology and summary of results

Over the past 8 years we have undertaken a number of clinical studies centred on clinical complexity which creates 4 groups: straightforward C0, locally complex C1, systemically complex C2 and most complex C3, which takes the form of a 2x2 table, with escalating complexity from C0 to C3.

We have undertaken studies for both elective and trauma conditions. We have found statistically significant differences between straightforward and most complex patient groups in a variety of parameters such as complication and mortality rates, recovery times and cost.

The future We are currently analysing results of a much larger cohort of knee replacement patients, and are aiming to apply the methodology to hip replacement and tibial plateau fractures. We hope to roll this methodology out to other Trusts and feel the methodology is suitable for any index condition.

Conclusions

- Patients' clinical complexity is a key factor in determining treatment outcomes. This is currently not done adequately.
- It confirms summative interaction between local and general factors which is been under-represented in historic texts, literature and current registries.
- Complexity classification has increased the understanding of all the teams involved with patient care, improved patient counselling, surgical skillset and operating time allocation and cost awareness.
- The methodology fits with contemporary studies in other fields such as macro-economics.
- The methodology of application and use of this method of patient stratification is likely to have universal applicability.