107 DEVELOPING EFFECTIVE LEADERS

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The Health Educational England London Leadership Development Steering Group produced and implemented the Spiral Leadership toolkit for all postgraduate medical and dental trainees in the London region.

There is an urgent need to incorporate leadership development within the postgraduate training curricula to ensure the NHS has a robust pipeline of developing clinical leaders for 2020 and beyond.

The NHS Long Term and interim People Plans call for healthcare organisations and specifically Health Education England (HEE) to support leadership development through training programmes, as part of curricular and professional capabilities. Until recently there has been a lack of available structure for trainees, their supervisors and faculties within NHS organisations and HEE itself to implement this requirement.

The group examined available resources supporting the curriculum for future healthcare leaders and adapted an existing specialty school toolkit to make it widely applicable across all learner groups.

A wideranging stakeholder exercise ensured comprehensive coverage of all learner and educator needs from foundation schools to trainees preparing for and starting out in their first few years of their consultant posts.

Needs and resources were structured in a pragmatic and practical toolkit based around capabilities such as responding to a complaint, and leading a change project. The toolkit was reviewed by other regional leadership development leads for coherence across England. Educational leaders were upskilled in use of the toolkit and small-scale pilots in clinical oncology and dental training programmes started in 18/19. Other training programmes were given a 'soft launch' as part of annual induction, stressing the benefit to trainees.

The toolkit is available to download online with an opt-in sign up for updates. Please see: <https://www.lpmde.ac.uk/var/structure-of-training/spiral-leadership>.

108 NERVE CENTRE: ELECTRONIC HANDOVER

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Aims As the NHS patient numbers are continually increasing, we are facing unprecedented challenges to improve quality, reduce harm, eliminate waste and improve efficacy. A fundamental part of this is a reliable, safe and effective electronic patient handover system. In order to improve, we rely on confident leaders that can use technologies available to them and effectively integrate these changes into current practice.

Methods We used a current electronic observation platform being used within the hospital to create a digital handover. We had a very short transition with the old free typed Word documents being removed, which ensured that we had 100% uptake of the new system. We had centralised email feedback system to address any issues by accurately recording them and

acting appropriately. The approach to measuring the effects of the improvement, were mainly in its continued use. Since quantifying the improvement is not clear cut, we have used staff feedback to highlight the measurable improvements.

Results The project has been running 6 months and has been widely praised. We have successfully undergone a junior doctor rotation in April and August still maintaining standards. We have been approached by clinical leads for other specialties to discuss how this system may be of benefit to their directorates.

We have not only achieved what we set out to, but we have used this platform to continue expanding the use of technology for the T&O team and have several new themes to the project in development.

Conclusions It takes significant effort and resources to bring a project of this magnitude to fruition. Unfortunately, even with significant planning, getting teething problems are unavoidable, but creating the appropriate platform for feedback and acting on it is invaluable. The electronic handover is constantly an evolving work in progress but as yet, we believe making significant improvements to our department and the safety of the patients within it.

109 SPECIALISED SERVICES COMMISSIONING IN WALES: A FELLOWS PERSPECTIVE

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As a Welsh Clinical Leadership Fellow working within Welsh Health Specialised Services Committee (WHSSC) I have gained a new perspective on the Welsh NHS. WHSSC is responsible for commissioning specialist services in Wales and offers a wide arena in which to develop leadership skills. My fellowship has given me an invaluable insight into the way NHS specialist services are planned, prioritised and funded across Wales.

Specialist commissioning utilises an ongoing cycle of evaluation ensuring services bring value to patient's and the system. My project was to assess the potential for developing a specialist service for Pulmonary Hypertension (PH) within Wales, currently provided by NHSE. Drawing upon commissioning theory, quality improvement models and a value based healthcare approach, the work has assessed potential interventions that could be made in the commissioning strategy of this service in Wales. I have developed a new clinical network comprising clinicians in Wales and England involving multiple site visits and establishing a Welsh clinical working group. This project stream has run concurrently with mapping work against the commissioning governance structure.

A collaborative approach has been required to lead this project. Redeveloping an existing commissioning arrangement is complex and involves engaging with multiple stakeholders. Adopting an open and honest approach with regards to the intention of this project has been paramount. Certainly, any future Welsh PH service would be established with significant support from an NHSE provider therefore maintaining an excellent relationship with these external centres has been vital.

The project has provided significant challenges with regards to data access and engaging certain stakeholder groups. At the end of this year I have identified a range of service options

and established a clinical network. This provides a strong basis on which the commissioning team can take forward an option appraisal process.

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THE TRIGGER PROJECT: INTRODUCING ELECTRONIC PATIENT REPORTED OUTCOME MEASURES INTO RADIOTHERAPY SERVICES

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Patients receiving pelvic radiotherapy can experience long term GI side effects post-radiotherapy. The Trigger project identifies patients experiencing symptoms of radiation-related bowel toxicity using the ALERT-B questionnaire, and directs them to the appropriate clinician. Trigger is a service evaluation project, aiming to prove the utility of electronic PROMs, and to demonstrate the feasibility of a low-resource project as a model for collecting PROMs. It is a collaboration between Macmillan Cancer Support, the Royal College of Radiologists, and three NHS Trusts: Velindre, Imperial College Healthcare and Brighton and Sussex University Hospitals.

Patients register on the Trigger website, hosted by My Clinical Outcomes, and receive periodic emails to complete the short ALERT-B questionnaire electronically, to screen for long-term bowel symptoms which could have been caused by pelvic radiotherapy. If answering 'yes' to any of the questions, patients are directed to appropriate services. 6 months following the completion of their radiotherapy, patients are sent a separate questionnaire to evaluate the utility of the project.

336 patients registered in first the 9 months across the 3 sites. Patients with a range of different cancers signed up: anal (2%), bladder (1%), prostate (87%), rectal (4%) and gynaecological (6%). 43 patients (/65 (uptake 66%)) have answered their 6-month post treatment questionnaire, and 72% answered 'yes' to at least one of the ALERT-B questions. 85% of responding patients reported they found the Trigger project helpful.

These promising results show that electronic PROMs can be introduced in radiotherapy departments using a low resource model. The Trigger project works as a feasibility model, showing patients engage with electronic PROMs projects, and find them useful. PROMs for other tumour types could be collected in a similar manner, based on the low-resource model used here, using site-specific PROMs based on the ALERT-B tool.

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MEDISENSE TECHNOLOGY FOR BREAST CANCER

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Introduction It is not uncommon for a patient coming to the NHS to present with investigations and treatments done in EU countries and outside the EU for various medical and surgical conditions. Many times, reports are written in languages other than English and therefore does not contribute to medical consultations.

Another issue with the patients is that they feel helpless and frustrated when they can't understand what the reports mean for them. To resolve these problems, we developed a technology called Medisense is a medical report image capture, data extraction, validation and interpretation technology. By using this technology, doctors and patients can take a snap of the picture of any report and get an instant translation, interpretation and review of the report.

Study design In the current study, we carried out 97 cases of breast cancer histopathology reports of various patients. The test was carried out using a specified protocol in a test environment.

Results The study results show that in all the 97 cases, the image capture was successful. However, the data extraction was successful only in 93 cases. In 90 cases, the data interpretation was correct. In the 4 instances where image capture was not successful, the poor printing quality of the report (n=1), folds and creases in the report (n=1), and technical error (n=2) was responsible.

Conclusions Medisense will be a helpful tool in medical consultations when a patient arrives with a report in a non-native language. This would also help patients interview and interpretation of their medical reports. Further studies and improvements are required to optimise this technology further.

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NEW RAPID ACCESS UROLOGY CLINIC

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Rapid access urology clinics had been trialled elsewhere in the country with variable success. ED, urology consultants and registrars, and senior nurses (i.e. the stakeholders who would be directly impacted by this intervention) were involved in the decision to convert two side rooms to such a clinic in our DGH. The aim was to see non-elective urology patients efficiently to ensure prompt management and avoid admission where possible.

The proposal and initial data were discussed in the monthly urology governance meetings. The pilot started in August 2018. Patients could be referred by ED, GP, other hospital departments via the on call urology registrar or self-refer. Patients discharged from the urology ward were informed about this, as were ED staff, GPs, and other departments such as radiology and oncology. Feedback from patients and ED staff were welcomed and outcomes measured.

Data was collected prospectively during an initial 47-day pilot period and the subsequent three months. Each attendance was reviewed individually. The hot clinic saw 107 patients in the pilot period and 217 in the subsequent three months. ED avoidance was estimated at 61% in the trial