23 IMPROVING THE MANAGEMENT OF DENTAL TREATMENT FOR THE HOMELESS COMMUNITY WITH THE USE OF MOBILE DENTISTRY UNITS

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The chaos of homelessness and a high prevalence of previous trauma Results in self-neglect and therefore poor dental hygiene. It was found 99% of homeless people require dental treatment, however less than half completed their treatment plan. Reasons for this include dental anxiety and accessibility barriers, such as opening times and geographical inaccessibility. The lack of leadership and management focused on providing specific and suitable dental services for the homeless community leaves them with services that are not accessible.

Leading the way as a possible solution is a mobile dentistry unit (MDU) which would provide suitable dental care to the homeless population. It would be flexible, in location and time, and work collaboratively with an already established network of homeless service providers. In order to measure the success of this service it would be reviewed in areas including patient attendance, completion of treatment plans and patient satisfaction.

Although the initial financial cost would be high, £200,000, it would decrease the number of preventable hospital attendances and missed national health service (NHS) dental appointments. 55% of the homeless community miss their annual NHS dental appointments, and 30% attend hospital with dental complaints. Based on the 580 people registered at Exeter's specialised homeless healthcare general practice surgery, The Clock Tower Surgery, Exeter, this would save £65,000 per year. Therefore, this would result in a long-term financial benefit after four years. There is also an incalculable benefit of pain relief, improved self-esteem and improved oral hygiene for the patients treated.

In conclusion, successful management and leadership of MDUs would tackle the need for dental services suitable for the homeless community. An increase in oral health can increase self-esteem and help gain a sense of control, which in turn can support the process of people getting their lives back on track.

24 INFORMED CONSENT IN OBSTETRICS: A SURVEY OF PREGNANT WOMEN TO SET A NEW STANDARD IN INFORMED CONSENT FOR EMERGENCY OBSTETRIC INTERVENTIONS

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Respect for autonomy supports the rights of women to make their own decisions about care as laid out by the Supreme Court ruling on Montgomery (2015). Consent for emergency procedures in obstetrics presents a significant challenge. Consent obtained when a woman is exhausted, influenced by endogenous or exogenous chemicals or in fear of her unborn child's safety cannot be considered to be informed. An opportunistic survey of pregnant women in

Highland region was conducted over 6 weeks in community and secondary care antenatal clinics. Primary objective-determine women's current understanding of emergency obstetric interventions in labour to guide our work in achieving informed consent. Secondary objective-compare regional and Scottish national delivery data to allow realistic counseling of women regarding possibility of such interventions. Results were analysed and comments qualitatively explored. Labour and delivery expectations of survey participants were compared to regional and Scottish national delivery data (2018). We found that many women were uncertain regarding possibility of intervention. Both prim and parous women requested more information; some specifically asked for up-to-date statistics. Regional and Scottish national delivery intervention rates were comparable. Current intervention rates (by regional and Scottish national data) are significantly higher than expected. Our data is in keeping with Scottish data so this is likely an issue in other regions too. Our survey showed pregnant women may not have realistic expectations of delivery outcomes. Pregnant women need information based on regional and national data to foster realistic expectations of labour or delivery; empowering decision-making and ensuring peri-partum emergency consent is still informed consent. A multi-disciplinary approach to a novel means of obtaining informed consent will allow NHS Highland to lead the way in implementing change to improve the care of our pregnant women.

25 THE DARK OR LIGHT SIDE? INSIGHTS FROM THE GP-CONSULTANT EXCHANGE PROGRAMME

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Introduction and implementation Collaborative working across primary and secondary care is crucial to providing quality care. In this GP-Consultant Liaison scheme, 200 Consultants and GPs were strategically paired to enhance working relationships. Pairs hosted and visited each other's workplace. Our aim was to improve professional understanding, foster deeper partnership, ignite opportunities for innovation and quality improvement (QI) with co-owned local solutions. Submitted anonymous reflections were analysed for common themes. Celebrations of the shared learning took place regionally with affiliated NHS organisations. The emphasis was on compassionate leadership and next steps.

Impact Feedback obtained from 71(37.5%) participants was scaled from 1 (least likely) to 6 (most likely). In breaking barriers, individuals supported a regular primary-secondary care forum; weighted average score of 5.25, found the scheme useful (4.59), likely to take part again (4.83), consider new ways of working consequent to building better relationships (3.85). We observed production of leaflets on psychological support for patients in hospital consequent to insight obtained from primary care, sharing directories of primary care secretary contacts and restructuring of outpatient clinic letters to state 'For Information Only' or 'GP Action Required' resulting in

substantial time and cost savings. The liaison improved morale and insight. Common themes from reflections revolved around compassion, collaboration, complexity, efficiency and education.

Learning This scheme was an easy and enjoyable way to reconnect individuals and allowed professionals to learn about challenges we face within the NHS. As QI activity, the scheme resulted in simple local solutions for patients. It is a low-cost intervention that can be replicated within any organisation in the NHS. However, it needs a motivated and persistent individual to drive the project forward.

Developing Effective Leaders

26 ADOPTION OF THE EDWARD JENNER PROGRAMME IN MEDICAL UNDERGRADUATE TRAINING

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10.1136/leader-2019-FMLM.26

Aims Leadership is relevant and important to all Specialties. And the Leaders of tomorrow are the Student Doctors of today. There is a need for training, and Leadership and Management is a skill that can be learnt.

Methods To our knowledge, this was the first time in a UK Medical School that the Edward Jenner Leadership Program has been piloted for all First Year Medical Students. At Sheffield University Medical School the Leadership Training was launched and offered within 3 months of starting Year One. Pre and post questionnaires were used to evaluate learning and outcomes. The training was free and all online, requiring approximately 15 to 35 hours completed over no more than 6 months, with extensions if required. n=52 students opted in to the program.

Results

- There was a 23% increase in confidence to build team capacity.
- There was a 9% increase in confidence to build positive working relationships.
- There was a 17% increase in confidence to undertake various team roles including, where appropriate, demonstrating leadership.
- There was a 10% increase in confidence to undertake various team roles including, where appropriate, the ability to accept and support leadership by others.
- There was a 47% increase in confidence to demonstrate awareness of the role of doctors in contributing to the leadership of the health service.
- 48% enjoyed doing the Leadership Training course.
- 62% thought the Leadership Training course had made them a better leader.

Conclusions

The Results support explicit encouragement of Leadership Development in Year One of Medical School. This would preferentially be followed up in Years 2–5 with appropriate lectures, small group work, mentoring, and on the job learning with a reflective diary, and potentially through completion of additional NHS Leadership Academy programs.

Leading Innovation and Improvement

27 'FEEL UNSAFE AND NEED MORE DOCTORS OUT-OF-HOURS?' – JUNIOR DOCTORS' JOURNEY IN IMPROVING PATIENT CARE AT DISTRICT GENERAL HOSPITAL

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Aim Medical staffing level may not match the increasing demand to deliver safe and sustainable patient care especially during twilight out-of hours. Our aim is to evaluate Junior Doctors staffing (capacity) against medical admissions (demand) in twilight hours, implement a balance between demand and capacity, and evaluate its impact on the number of medical patients handed over to night on-call team.

Method The proposal was presented at Junior Doctor Senate, which was composed of junior doctors and chaired by Director of Medical Education (DME). Baseline data was collected on medical staffing level during twilight hours (5–9 pm) and the number of medical patients still waiting to be seen handed over to night team. The Results were presented at Trust-wide meetings. Invitations were received to present the data to the Trust Directors and Chief Executive. Same set of data was collected after the successful implementation of new twilight shift.

Results Data showed almost half (47%) of all medical referrals were received between 4pm and midnight. After the implementation of twilight shift, the average number of medical staffing level increased from 4.3 to 6.6 ($p<0.01$) and the average number of medical patients waiting to be seen at 9pm significantly dropped from 14.6 down to 6.8 ($p=0.02$). Student's t-test was used for statistical analysis. Feedback (no=39) was collected from all staff groups in the Trust after the implementation, which showed 84% of staff agreed or strongly agreed that increasing staffing level improved safety of patient care.

Conclusion Collaborative working between Junior Doctors, DME and Trust executive resulted in identifying gaps in medical staffing during twilight hours. Our work demonstrates that junior doctors are potentially a powerful group of clinical staff, by speaking up and taking active roles they can lead a culture of positive changes in the Trust.

28 UNDERSTANDING AND ADDRESSING MEDICAL WORKFORCE CHALLENGES IN A LARGE UNIVERSITY TEACHING HOSPITAL. IS THE ANSWER ALWAYS MORE, HARDER, FASTER OR SIMPLY SMARTER?

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Aims The project was conducted across all medical inpatient specialties within a UK teaching acute trust comprising a large hospital with secondary/tertiary services and a district general hospital (DGH). The trust faces the these challenges: