and post course quizzes specifically on the management of acute strokes were also distributed to track the knowledge change.

Strategy for improvement The simulation courses will be repeated in this working year for medical trainees within our trust and our neighbouring trust. Feedback from the initial courses was overwhelmingly positive but we will continue to review and adapt our scenarios to address trainee concerns, as well as liaising with other relevant specialties to develop realistic, high-fidelity simulations, such as the critical care team. We will also aim to follow up with those who completed the course after 2 months of being a medical registrar to ask if thereâ€ ™s anything else that wasnâ€ ™t covered that would be helpful to include.

36 MEDICALLY SAFE FOR DISCHARGE (MSFD): REDUCING DOCTOR INPUT IN MSFD PATIENTS ACROSS GERIATRIC MEDICINE WARDS AT A DGH IN SOMERSET

[1]Hannah Parker, Georgia Asher. [1]*Care of the Older Person's Department, Musgrove Park Hospital, Somerset NHS Trust, UK*

10.1136/leader-2023-FMLM.26

Context Musgrove Park Hospital is a district general hospital in Taunton, Somerset, in the South West of England.

Issue/Challenge Increasingly NHS hospitals are under capacity pressures. Since the COVID pandemic, Musgrove Park Hospital is struggling with high numbers of medical admissions, coupled with increasing lengths of patient stay. This is multifaceted but largely due to a lack of social care packages and pressures on community services.

Assessment of issue and analysis of its causes

The pressure on social care has resulted in increased numbers of patients in acute hospital beds that do not have a â€ ˜criteria to resideâ€ ™. These patients are deemed medically safe to be residing in their own homes or residential care. They do not require inpatient medical care and therefore a routine daily doctor review.

Impact This project looked to trial a system where medically safe for discharge (MSFD) patients are identified by the medical team (senior doctor) and are flagged as not requiring daily ward round reviews. These patients are discussed daily at board rounds and continue to receive nursing care and therapy input. The MDT are encouraged to escalate concern about a â€ ˜MSFD patientâ€ ™ to the medical team who will then review as clinically indicated. This would allow rationalisation and re-prioritisation of doctor-time to the most unwell patients.

Intervention We initially trialled this project on Mendip, a 19 bedded care of the older person (COOP). A rapid PDSA cycles allowed the creation and improvement of a sticker to identify MSFD patients. This A6 sticker was placed in the medical notes as soon as a patient was deemed MSFD. It included an option for highlight any ongoing issues that would otherwise be addressed as an outpatient, and signalled that the patient would not be included on daily ward rounds.

Data collected during the 3 week trial period showed 46% of bed days were occupied by MSFD patients. An average of 8 MSFD patients were not reviewed each day, with 0.6 unplanned reviews of these patients needed due to MDT concern, saving an average of 7.4 patient reviews per working day. In addition, 3.3 hours/day were saved, allowing rationalisation of doctor time and resources to understaffed, busier wards whilst not causing detriment to patient care. This equates to half a doctor per day per medical ward.

Involvement of stakeholders, such as patients, carers or family members:

Creating a MSFD process required multi-disciplinary working from medical teams alongside nursing and therapy colleagues, as well as the wider hospital management team. There were no complaints from patients or family members as a result of this change, and no adverse outcomes to patient care were noted either.

Key Messages The use of a MSFD process has helped our hospital to address the challenges of capacity and demand for limited NHS resources, with respect to both the physical bedspace and precious doctor time. This has enabled reallocation of that saved time to care for and treat more patients, as well as provide education to the next generation of medics.

Lessons learnt The current NHS bed crisis will not be solved by a 'quick-fix' as the situation is complex and multi-faceted. However, projects like this enable the resources we do have to be used effectively and efficiently. We were fortunate to have buy-in from the hospital management when our trial was still in infancy which enabled rapid testing and development of the process, due to support from members of the MDT throughout the hospital. This may not always be the case for other projects.

Measurement of improvement Data was collected to measure the number of patients being seen each day on the ward, and the time saved from not seeing MSFD patients. We balanced our intervention by measuring the number of complaints from patients or families, as well as the number of unplanned reviews from patients who became sick. The work on Mendip was presented to the hospital clinical leadership group alongside the date we had collected to support its efficiency and safety, who subsequently approved the standard operating procedure we wrote to formalise our work. This is currently being rolled out within the care of the older person department at Musgrove Park.

Strategy for improvement The next step of the project is to establish MSFD ward. This cohorts the patients who would otherwise be discharged into the community if their pathway/care was available. The ward will require reduced doctor input, allowing medical staff to be redistributed to busier parts of the hospital, with the ultimate aim to run this as a 'doctor-free' ward, similar to the care provided in the community.

37 A NETWORK APPROACH TO SUPPORTING THE CAREER DEVELOPMENT OF SPECIALTY AND ASSOCIATE SPECIALIST (SAS) DOCTORS CHESHIRE AND MERSEYSIDE PALLIATIVE AND END OF LIFE CARE NETWORK

[1]Paula Powell, Helen Bonwick, Esraa Sulaivany. [1]*Cheshire and Merseyside Palliative and End of Life Care Network*

10.1136/leader-2023-FMLM.27

Context Cheshire and Merseyside Palliative and End of Life Care Network (PEOLC)

I am submitting as Consultant Clinical and Workforce Lead for Cheshire and Merseyside PEOLC Network. The co-authors are Associate Specialists who both have senior clinical roles in their organisations and were co-Chairs of the APM SAS

doctors committee. The work described has been supported by our Strategic Clinical Network Programme Manager and the project team.

Cheshire and Merseyside have led on supporting the development of SAS doctors for the last 10 years. An action learning set in 2012 developed the first Training and Development Framework for SAS doctors in palliative medicine and this has been updated a further 3 times, most recently in 2020. This has been accepted across the NW and by the Association for Palliative medicine.

Our Trainers committee fully supports SAS doctors and there is a SAS representative on the group who reports issues regularly.

Issue/Challenge Medical workforce challenges are apparent in all specialties. A recent specialist palliative care workforce review for Cheshire and Merseyside showed that we have a 20 WTE gap in Consultants across all settings. We had found in a survey of SAS doctors working in palliative care that terms and conditions of service and opportunities for career development were often lacking and SAS doctors were unsure where they could seek guidance and help when they worked in the voluntary sector (often hospices)

The impact of this is that many experienced SAS doctors were not getting the opportunity to fulfill senior clinical roles and contribute to service development or felt unsupported when they were.

It was also the case that SAS doctors in hospices who were required to be responsible clinicians or medical directors had no framework to support them in their own development or an assurance process of their skills and competencies.

Assessment of issue and analysis of its causes

In 2021 a survey of 35 SAS doctors in the Network there were 14 responses. Of these 43% had worked in palliative care for more than 10 years and 30% expressed a desire to use the CESR route to gaining specialist registration.

They also identified significant variation in education and training opportunities.

This survey was presented to an annual SAS doctors development day in 2021 and the Trainers Committee for the NW.

Impact As a result of the survey a working group was established to consider how organisations could support the development of SAS doctors and allow them to gain experience outside of their own organisation which is of benefit to the individual and organisations they work for.

Previously organisations had been reluctant to allow 'swaps' of doctors because of perceived HR challenges or ensuring 'like for like' competencies.

A hospice and regional cancer centre agreed to test this out and subsequently 3 doctors were rotated over a period of 6 months between the 2 sites. The individuals experience of this was presented to the local trainers committee in Dec 2021. They saw a number of benefits including working with different teams, the challenges of different approaches in a tertiary cancer centre and a hospice in patient unit and community team. All felt more confident in their clinical and leadership development.

2 are planning CESR applications in the next 12-18 months.

Currently a SAS doctor is rotated with an IMT3 trainee from a hospital setting and a further hospice-hospice swaps are planned next year.

Intervention In addition to supporting rotations for SAS doctors we have addressed the issue of senior SAS doctors in leadership roles in hospices who are often required to step in to Responsible Clinical or Medical Director roles sometimes with relatively little experience or support.

The authors subsequently developed a Framework to support SAS doctors acting as Responsible Clinicians or Medical Directors in Hospices. This describes the skills and attributes required and the support that should be expected of an organisation to support them. This has been acknowledged as a key document in support of SAS doctors by the National Clinical Director for Palliative and End of Life Care.

We now have a SAS doctor group as a formal Network group that has an annual development day and quartely meetings.

All SAS doctors are able to attend the education programme for specialist trainees across NW which was not happening before.

The resources we have developed could be used by networks and organisations to support SAS doctors.

Training committees could engage with SAS doctors to understand their training and education needs and seek local ways to support this.

Involvement of stakeholders, such as patients, carers or family members:

Patients were not directly involved in this development work

Key Messages SAS doctors are a valuable and significant part of the specialist workforce, many are hugely experienced but career development can be challenging because of the focus on service delivery.

Our approach includes identifying and valuing the expertise and contribution of SAS doctors and gives them opportunities to develop their careers through resources, opportunities to gain experience beyond their own organisation, education and training.

Developing experienced clinicians in to senior roles benefits patients and responds to the significant workforce issues that we have nationally

Lessons learnt This work is very much on going. We describe the key milestones over the past 10 years in creating our current model across Cheshire and Merseyside to support doctors in SAS roles to develop their careers.

The key challenge is the requirement for service provision often placed on SAS doctors that can impact on their ability to access development opportunities in favour of doctors in specialist training. This is short sighted as we have huge gaps in consultant numbers and doctors in training will not be able to fulfill these.

Measurement of improvement We are expecting 4 CESR applications in the next 12-18 months.

The Responsible Clinicians and Medical Directors Framework is currently being used in 3 hospices who wish to ensure support for their SAS doctors in senior leadership roles

Strategy for improvement Our next step is to gain recognition for the Responsible Clinicians and Medical Directors Framework by the Association for Palliative Medicine so this can be a resource nationally for hospices.

39 DEVELOPING MEDICAL LEADERS IN HEALTHCARE IMPROVEMENT SCOTLAND

[1]Ruth Stephenson, Kirsty Kilgour, Carole Anne ONeill, Simon Watson. [1]*Medical Directorate, Healthcare Improvement Scotland*

10.1136/leader-2023-FMLM.28