Peace takes time to build but initial steps have been taken in open channels of communication.

Funding has been secured to offer joint CPD meetings for nurses working alone in remote facilities. This has already improved morale.

Meetings held every 3 months and facilitated by a Kenyan NRT lead open to all stakeholders and community representatives give opportunity for feedback.

8 DOES COLLABORATIVE LEADERSHIP MAKE A DIFFERENCE IN NHS HOSPITALS?

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10.1136/leader-2023-FMLM.8

Context The intervention was done in Glan Clwyd Hospital, Wales, UK. Mortality Review Group (MRG) is involved, and all the staff in the hospital are the target audience.

Issue/Challenge There was no regular Mortality Review and learning from deaths in Glan Clwyd Hospital (YGC). As a result, 408 mortality reviews are to be completed. It was estimated that 12 months were needed to complete those reviews.

Assessment of issue and analysis of its causes

The 5 Whys approach was used to assess the causal factors, and the SWOT analysis was used to identify the size of the challenges and strategic opportunities. The stakeholders were involved in the multidisciplinary team (MDT), and analysis was disseminated using the PowerPoint presentation.

Impact Good robust multidisciplinary team governance process at the Glan Clwyd Hospital to review all adult deaths. All 408 death reviews were completed within eight months. Regular weekly mortality review is in place. Patient care quality and safety are continuously improving. Staff and professionals benefit from improving their reflective learning practices and continuous learning. Collaborative leadership and continued support with motivation are the factors that led to improving and sustaining the process.

Intervention From the intervention undertaking, all adult deaths in YGC are being reviewed without Glan Clwyd Hospital. Shared learning from Deaths: Regular News bulletin published with learning themes, lessons learned and good practices. Collaborative learning across-the-professional boundaries: Acute care and primary care linked together to learn from reflections.

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

Patients are not involved in this project. Medical/Surgical Consultants, Administrative and Primary Care representatives, Head of Nursing (Acute care and primary care), Pharmacy representative, Senior Trainee, and Deputy Medical Director (Chair) were involved.

Key Messages Through collaborative leadership, managers and executives can create an inclusive environment that energises teams, releases creativity, and cultivates a work culture that is both productive and joyful. This approach will make a safe and efficient health care system.

Lessons learnt By providing collaborative leadership, Medical leaders can improve health by get diverse opinions and ideas among teammates to build strategies and solve problems. As a result, employees are more engaged, feel trusted and are more likely to take ownership of their work.

Measurement of improvement The number of pending case reviews used to measure the effectiveness of the improvement. Currently no pending mortality review in Glan Clwyd Hospital. All adult deaths are getting reviewed on time.

Strategy for improvement TOWS Matrix was used for generating strategic options. Terms of Reference (TOR) were created, and Mortality Review Group -a multidisciplinary team- was formed. The strategies used to implement the improvements are the collaborative leadership style and reflective learning practices with open, transparent, honest discussions with feedback.

9 COLLABORATIVE LEADERSHIP DRIVES MEANINGFUL DIGITAL TRANSFORMATION

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10.1136/leader-2023-FMLM.9

Context This work was undertaken at the Kidney Transplant Unit at Manchester University NHS Foundation Trust, UK. The multi-disciplinary team consisted of clinicians, user experience designers, software developers and project/business managers (included as co-authors).

Issue/Challenge Kidney transplantation is a complex clinical service with patients crossing speciality and organisational boundaries as they transition from chronic kidney disease to kidney failure and ultimately transplantation. However, clinical data captured along the pathway does not follow the patient. This results in missed communication, delays and increased burden on staff to manually manage data across disparate sources.

Assessment of issue and analysis of its causes

Current NHS IT infrastructures do not readily support data sharing across organisational boundaries with poor levels of interoperability between electronic health records (EHRs). To better understand this problem in the context of kidney transplantation, we undertook a national survey of all 23 kidney transplant centres in the UK.

This identified that most transplant centres have mature EHRs implemented. However, due to due to the multi-disciplinary and cross-centre nature of the service, EHRs were unable to meet the necessary workflow requirements. This was further compounded by an inability to transfer data between EHRs at referral centres and transplant centres, resulting in a dependence on post or scanned files attached to email.

In order to overcome this challenge and develop solutions that meet the requirements of the service, we applied a collaborative codesign methodology. By directly involving clinical, academic and health IT stakeholders we aimed to create an environment of shared ideation.

Through this approach we were able to gather key requirements from front-line staff and iteratively design a usable prototype. Key features of the prototype were the ability to

surface data across organisational boundaries and provide a transplant-specific view that mirrored the patient journey. Involving stakeholders in the design process created a sense of shared ownership across the leadership team, resulting in high levels of engagement with the project.

Impact The impact was two-fold:

1. The direct impact of the prototype solution was to allow healthcare professionals to consider new ways of working. The trust underwent a wider digital transformation through the implementation of a new EHR and results from our work directly fed in to this.
2. This project identified the value of collaborative leadership and shared ownership to develop healthcare solutions that meet service requirements and are more likely to bring benefits to patients.

Intervention The key intervention was a series of user workshops with stakeholders to gather requirements, elicit feedback and drive an iterative design process. As the clinical lead on this project I recognised the value of sharing responsibilities with leaders across disciplines. By assigning trust to individuals with domain expertise we were able to design a potential solution that was well received by the clinical team. Figure 1: reproducible applied codesign and workshop methodology.

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

This project was aimed at improving clinical workflows and IT support for healthcare professionals. However, we envisioned any IT solution we developed may benefit patients through a patient-facing application. We thus involved the Kidney Patient Involvement Network and gathered early requirements from patients. This mainly highlighted how patients would like to be kept better informed on where they are on the pathway and what their transplant status is.

Key Messages

1. IT systems are currently unable to support clinical workflows in kidney transplantation
2. Health IT systems must be interoperable by design to meet the needs and requirements of contemporary services
3. Effective engagement of leaders across disciplines can create dynamic and effective teams to tackle pressing healthcare challenges

Lessons learnt

1. Open–mindedness and empathy is critical when working with leaders from different disciplines
2. As clinicians we can play a critical role in focussing project teams on the common goal of improving healthcare
3. If doing this project again, I would have formally engaged a patient as part of the leadership team

Measurement of improvement We gathered qualitative feedback from healthcare professionals during the final user workshop. Comments included statements such as: 'a system this like would be useful for me'.

Strategy for improvement This project was undertaken in an agile-inspired iterative approach gathering feedback from stakeholders throughout its life cycle. Findings have now been incorporated in to a wider EHR implementation and a report has been compiled which will be presented to NHS Blood and Transplant.

10 CASE-LEVEL PLATFORMING OF COMPLEX CASE MANAGEMENT: THE COMPLEX CASE AND RECOVERY MANAGEMENT FRAMEWORK ('THE CCARM')

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10.1136/leader-2023-FMLM.10

Context This is work carried out in the UK North West region. It stems from a DBA project on value-based healthcare, and a collaboration with Mersey Care NHS Trust's specialist Intellectual Disability & Autism (ID&A) service. The aim is to conceptualise a service platform to better support complex case management. This is a proof of concept project, rather than a conventional service improvement project. It is of interest to service developers and practitioners looking to develop new approaches.

Issue/Challenge Complex case management (CCM) is at the heart of much healthcare. Practice should be collaborative, individualised, and focused on 'what-matters'. Support is needed for case-level leadership to make such practice a reality. UK Intellectual Disability and Autism (ID&A) practice is a relevant exemplar area to explore. Most initiatives focus on service-lines, not case-level operations. Collaborative service platforms to structure care are useful as 'micro-foundations for value co-creation' (Storbacka et al, 2016).

Assessment of issue and analysis of its causes

For case-level, collaborative strategies, challenges include clarifying the focus of care: the person at its heart, with other relevant practitioners involved. With service-users and others, how is complexity of need sensibly captured? How are myriads of potential resources and practices integrated into care strategies, with participants, delivering valued outcomes? Case-level leadership needs support to coherently hold these challenges together to good effect. What is an appropriately co-designed service platform that enables such choreography?

Impact The first issue is the development of an acceptable platform with service-users and their diverse supporting stakeholders

The second issue is activating such care-platforming into every day practice, with suitable support and assurances.

The promise would be:

- Better engagement with service–users, family, and participant practitioners.
- Better integration of practices and resources within the care journey.
- Generation of fresh ideas, whilst delivering richer, more democratic outcomes.

At this stage the aim is simply that the approach demonstrably works in practice: i.e 'proof of concept' (see below).

Intervention The complex case and recovery management framework (the CCaRM) is a platforming tool co-developed within ID&A services (Spurrell, Potts & Shaw, 2019). The core concept is mapping practices against 'what might generate value' within cases. Consistent with service-value literature, 6 themes emerged:

- 'Circle of support'
- 'About Me'