Aims and objectives of the research project or activity

1. To learn from clinical leaders in other NHS organisations regarding how they operate within a 'single front door' model.
2. To review how the current PED nursing and medical team perceive the existing referral processes, identifying any key areas for improvement.
3. To liaise with all community and inpatient paediatric speciality clinical leads to review existing referral processes.
4. To explore alternative patient pathways which avoids unnecessary admission or which better utilises other team members or resources.
5. To ensure referral pathways take into consideration patients and families who are the most vulnerable.
6. To collaborate with the new hospital planning team to ensure the patient pathways are futureproof and central to the planning processes.

Method or approach Virtual and face-face meetings were held with consultants from four different NHS hospital trusts with a 'single front door' policy. Notes were taken and shared with the team responsible for the planning of the Paediatric Emergency Department (PED) within the new Leeds Children's Hospital.

Questionnaires were distributed to all appropriate nursing and medical staff who worked in the existing Leeds PED in August and September 2023. The questionnaire explored issues such as confidence levels referring to specialties, awareness of outpatient services and experience of effective pathways previously used.

All community and medical specialties were also contacted to provide information regarding referral options. This information was provided via completion of a separate questionnaire or verbally in meetings. Engagement in this project was encouraged through presenting at the Clinical Lead meeting, departmental meetings and more widely in meetings with members of the local Integrated Care Board and Public Health department.

The information regarding speciality referral options was collated into a 'Patient Pathways Handbook'. This will be available on the CEM Books App, used by the ED team, and the Trust intranet.

Findings Questionnaires were completed by twenty-three members of the Leeds PED team. The level of confidence in referring was very variable with 26% of the medical team feeling not confident in referring a patient direct to speciality, 30% feeling neither confident or not confident, 26% feeling confident and 18% feeling very confident. A similar spread of results was also seen in response to a question on outpatient services. Rapid access clinic and community clinics were identified as the services which caused the most confusion. Twenty-one participants (91%) felt that it would be beneficial to have a handbook detailing available referral pathways.

The Leeds PED team consists of consultants and Advanced Nurse Practitioners, many of whom have worked in the department for several years. There is also a cohort of doctors and nurses who are allocated a rotation in PED as part of their training programme. It is therefore reasonable to assume that the variability in confidence levels can be largely attributed to the difference in time spent working in the department.

Key messages Previous research has identified three key barriers to successfully referring patients from emergency departments to specialties: variation in referral processes and information required, differences in organisational culture and communication issues. This handbook aims to minimise these barriers in Leeds PED through clearly identifying all inpatient and outpatient patient pathways between PED and all specialties.

The interactions with the speciality teams facilitated discussions regarding methods for appropriate admission avoidance. This included highlighting available community paediatrics services, identifying which outpatient services could be accessed by PED clinicians and identifying direct communication links between PED and speciality teams. The handbook has received widespread support from all Clinical Leads and is being expanded to incorporate paediatric surgical specialties.

This project highlights the importance of collaborating with leaders from across an organisation to optimise how different teams interact and ensure patients are seen by the right person, in the right place, at the right time.

42 IMPROVING PATIENT TRANSITION BETWEEN SECONDARY AND PRIMARY CARE POST-OPERATIVELY: A QUALITY IMPROVEMENT PROJECT ON SICK NOTES

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Introduction Working relationships between primary and secondary care, and in particular, guidance around specific roles, is not always clear. This project identified a gap to improve patient experience by championing good working practices between primary and secondary care, particularly around the completion of sick notes (Med3 certificates). We noted that anecdotally there was some discrepancy in the length of sick notes provided in one Obstetrics and Gynaecology department, and a lack of clarity on the role of primary care to provide these for patients who had been discharged from hospital after an operation. As clear national guidance was available, we undertook this project to educate consultants on these roles and to facilitate potential changes in practice going forwards. Completion of sick notes in line with this national guidance is likely to improve patient experience and also improve working relationships between general practitioners and hospital consultants.

Aims and objectives of the research project or activity The aim was to educate and influence the behaviour of Obstetrics and Gynaecology consultants, which could potentially improve patient experience, enhance interdisciplinary working, and increase understanding of the responsibilities of primary and secondary care clinicians. Specifically, we focussed on national guidance from the Department of Work and Pensions which advised that patients should be provided with a full sick note at the time of discharge from hospital, reducing the need for further appointments in primary care for this reason. The objectives of this project were to improve understanding of the rationale behind why the secondary care doctor was best placed to issue a sick note for the likely forward period for patients discharged from their care after an operation, and influence the practice of consultants in the department to improve patient outcomes and ensure effective use of resources in primary care.

Method or approach The project was completed as part of the RCGP specialty training curriculum, which includes a quality improvement activity each year of training. We administered a baseline survey to all department consultants about their practice of issuing sick notes, using a hypothetical post-surgical gynaecology patient scenario as an example. We then provided information around the national guidance for sick notes via email, including screenshots and the link to a webpage, as well as the results from the first survey. During this time, informal ad-hoc discussions about the project and the guidance took place with consultants and other senior doctors, particularly when asked to issue a sick note in the department. We then administered a follow up survey, using the same hypothetical scenario, to identify whether practice or thoughts had changed in the department.

Findings Although this was a small project, the final survey showed that the proportion of consultants who understood the role that secondary care doctors play in providing sick notes increased from 46% to 80%, following the provision of information and guidance. Although this project involved a hypothetical scenario, this change in thinking could demonstrate a change in practice across the consultant body, which over time, may add up to a significant reduction in GP appointments in the local community which are made solely for the purpose of extending sick notes after gynaecological surgery. This could potentially lead to improvements in patient experience (as GP appointments are often difficult to obtain) as well as improved working between primary and secondary care. However further work is needed to expand this project to observe the effect on the issuing of sick notes going forward, as well as perspectives on working practices between consultants and primary care, and the impact on patient care.

Key messages

- Working relationships between primary and secondary care could be improved if roles and responsibilities are clearly defined and shared
- National guidance advises that sick notes for patients who have had a hospital admission should provided by secondary care providers for the full expected period that they will be unable to work, to reduce the need for GP appointments solely for the purpose of issuing a sick note. Following this guidance has the potential to improve patient experience, and improve the working relationships between primary and secondary care, as well as appropriately diverting NHS resources.
- Simple educational information and discussion can have an impact of potentially influencing changes in practice and improvements in working relationships, however further work is needed to ascertain the impact of these changes.

43 TRUST-WIDE MEDICAL ROTA REVIEW- CONSIDERATIONS AND LESSONS

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Introduction As a Darzi Fellow in a London mental health trust, my challenge entails a review of medical rotas for junior doctors (JDs), which are suboptimal and problematic. The challenges of service transformation, growing complex clinical needs, staffing levels, and patient safety all feed into this challenge. There is a drive for positive change alongside collaborative approaches to ensure stakeholder buy-in for sustainable change.

Medical rotas and staffing had not been reviewed, despite considerable changes in acuity and service configuration resulting in workload variation across sites

Concerns around work intensity, patient safety, and staff wellbeing arose, compounded by limited numbers of JDs on-call.

The rota review will address this by changing rota patterns and staffing across two busiest sites, improving adherence with JD contractual requirements, and optimising patient safety and flow to accommodate growth and demand.

Aims and objectives of the research project or activity Collaboration and scoping of concerns through stakeholder mapping required engagement with doctors and others impacted: ward staff, consultants, site leads, and Approved Mental Health Practitioners.

An options appraisal (including fact sheets to mitigate concerns) was drafted and financial implications explored. All options were discussed with stakeholders, prior to approval by Training Programme Directors (TPDs), the Director of Medical Education (DME), and Trust Board.

Codesign of proposals with stakeholders, especially JDs, was pivotal for buy-in and insight from staff working shifts.

Method or approach This review intends to improve the structure of the medical rotas, equity of workload distribution, JDs' wellbeing (through a sense of co-designing of change), and retention and recruitment. These changes should benefit patient flow and patient safety as doctors work in better staffed environments, improving care.

Complexity of medical rotas is not specific to this Trust. A neighbouring organisation has already asked us to share our learning and we anticipate that others can learn from our approach.

Barriers to implementation include resistance to changes in structures, and conflicting priorities of stakeholders. Joint leadership across operational directors who hold responsibility for budgets and service safety and effectiveness may be needed, including the medical directorate responsible for leadership and postgraduate education of doctors. Split responsibility may have contributed to failures to address these challenges.

Medical rotas are contentious, and stakeholders had competing priorities and varying views.

We took a whole system view and invested time in defining problems through iterative enquiry, compromise, and understanding concerns rather than racing to quick solutions that didn't address problems sustainably.

Leadership styles and approaches to change work are a core focus on the Darzi programme, and informed our approach.

JDs and JD representatives, finance, human resources, rota coordinators, TPDs, DMEs, heads of service, and board members engaged in the review.

The JDs' Contract, Health Education England code of practice, and the trusts' standard operating procedures were complied to.

Positive practice from neighbouring organisations were also examined.

Findings There are recurring themes in our approach to complex problems in the NHS and lessons to be learned through how we approach problems, collaborate with neighbouring Trusts, and coproduce solutions that have buy-in from stakeholders.