45 ARE WE UTILISING OUR DENTAL WORK FORCE? A STUDY FROM ONE DENTAL INSTITUTION

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10.1136/leader-2024-FMLM.45

Introduction We surveyed dental care professionals (DCPs) across dental specialties in a dental hospital in London. At the time of the study, the first authors were dental core trainees with a target audience of the whole dental team including dental policy makers at the institution.

DCPs are trained in a large scope of practice. We investigated whether these skills were being fully utilised in our institution. Considering current NHS challenges in dentistry, such as patient waiting times, we were keen to explore ways we could overcome these to improve patient care.

Aims and objectives of the research project or activity We distributed questionnaires to DCPs across all specialties. Respondents included dental nurses, dental therapists, dental hygienists, clinical dental technicians and dental technicians. We explored their scope of practice and trained skills. We assessed the extent to which their skill set is utilised and what further skills/CPD they would like to be trained in. Our findings were formally presented to our clinical director and consultant in dental public health discussing barriers and possible solutions.

Method or approach Our impact is widening scope of practice initiatives for DCP's leading to improvement of patient care. The anticipated benefits are; adoption of an open team culture where DCPs can use their skill set working alongside dentists; expanding multi-disciplinary care; improving relationships and treatment planning between clinicians. Barriers to change relate to existing care systems and significant change is required from different departments involved in NHS framework of care. A broader scale study and long term follow up will aim to gather essential data for large scale improvement within the NHS.

Our proposed changes

- Encourage dentists to involve DCPs in their treatment plans, ensuring all diary slots are filled.
- Moving DCPs to different specialty departments, encouraging engagement from specialty dentists and undergraduate students.
- A team culture where DCPs feel empowered to voice their concerns
- Boosting clinicians' confidence and widening scope of practice initiatives, refresher sessions established for education on treatment planning for DCPs.
- Supporting DCPs to attend CPD programmes with allocated study allowances.
- Conduct broader-scale studies with other institutions to gather data for improvement.
- Engage with established integrated care systems to widen the scope of practice so DCPs can work in primary, secondary and tertiary care setting.

These interventions should be reproducible amongst all secondary care NHS services to work to reach the 18-week target of referral to treatment (RTT). DCPs working to their full scope of practice can contribute to optimisation of service provision and can inspire involvement in more leadership duties.

Findings We aim to broaden our survey to encompass a larger pool of DCPs and include other institutions. Additionally, involving clinical leads who possess valuable insights into the inner workings of their various departments, can identify practical ways to support each department in achieving its desired goals. This collaborative approach can lead to more effective and holistic improvements in the service.

Our results established a baseline consensus on the current utilisation of the dental team and attitudes towards this. Following our proposed interventions, we are monitoring via audits to assess how well they are being executed and their impact. This has been done by tracking CPD participation, conducting further surveys, monitoring waiting times and regular meetings with the dental team.

Following the implementation period, we will conduct service evaluation encompassing a variety of data sources, including feedback from DCPs, clinical leads, consultants, and relevant quantitative data including waiting times for patients. We will analyse changes, improvements and trends compared to data prior to interventions. This will include identifying any shifts in attitudes, improvements in dental team utilisation, and overall satisfaction among DCPs. It is essential that we maintain transparent communication with all stakeholders, including DCPs, clinical leads and consultants. This will be of interest to NHS policymakers and commissioners.

Key messages We must aim to improve the efficiency and effectiveness of our services. Patients are on long waiting lists leading to time off school/work, pain, premature tooth loss and mental health distress. The culture of our current health care system must adapt to these ever-changing needs and support DCPs to prioritise patients' best interests.

46 ENHANCE: SUPPORTING INTEGRATED CARE SYSTEMS IN MEETING THEIR LOCAL HEALTHCARE PRIORITIES AND WORKFORCE DEVELOPMENT NEEDS

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10.1136/leader-2024-FMLM.46

Introduction

- Integrated care systems (ICSs) were established in 2022 to meet the needs of local populations
- ICSs have responsibility for workforce development of health and care staff in the locality
- NHS England's enhance programme is an educational development offer, applicable to all health and care staff (including non-clinical), with emphasis on system working, health inequalities, environmental sustainability and population health, aligning to ICS priorities
- Learners are encouraged to develop their leadership skills through service improvement projects and collaborative learning activities.

Aims and objectives of the research project or activity

- enhance aims to address the educational requirements that can support sustainable workforce planning and delivery of integrated person-centred care through initiatives which prioritise staff wellbeing and self-directed professional development.
- Its flexible place-based offer aims to allow ICSs to address their local health priorities whilst encompassing the values of enhance and developing and retaining their workforce.

Method or approach

- enhance was piloted by seven regional trailblazers, with two (NEY and SW) closely aligned to local ICSs.
- Tailored offers were developed for multi-professional teams covering different geographical footprints. Mixed methods delivery included expert presentations, access to online learning resources, Action Learning sets, community and cross-sector 'field trips', and quality improvement projects.
- Building on this success, ICSs across England were given the opportunity to bid for funding to run their own place-based enhance offer. Two ICS pilot bids in Norfolk & Waveney and Kent & Medway were accepted and will launch in 2024. Further ICS bid submission opportunities will be available in 2024. These will use enhance domains and values to encourage and explore system working, and to engage and equip the workforce to address local priorities.

Findings

- enhance delivered effective and enjoyable multi-professional training to clinical and non-clinical health and care workers, breaking down professional silos.
- Feedback (qualitative and quantitative) showed improvements in knowledge, skills and attitudes about health and care systems and teams.
- Participants gained accredited CPD with some progressing to PGCert.
- Quality improvement projects delivered benefits for patients, teams and the environment, whilst developing leadership skills for learners.
- The NHS Long Term Workforce Plan (LTWP) has identified expansion of enhance programmes to ICSs as a priority to further develop generalist skills for all health and care professionals.

Key messages

- Enhancing generalist skills within the workforce is critical in managing increased patient complexity in a changing healthcare environment, as highlighted by the NHS LTWP.
- enhance trailblazer pilots demonstrated that learning across multi-professional teams, based on local population health needs, can enhance the skills of the local workforce and deliver service improvements whilst developing generalist skills.
- Further expansion through ICS pilots will provide more place-based offers tailored to local health needs which prioritise patient care and professional development of staff.

47 QUALITY IMPROVEMENT TO SUPPORT EMERGENCY DEPARTMENT EXIT FLOW

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10.1136/leader-2024-FMLM.47

Introduction As Divisional Medical Director from September 2018 to May 2022 and College Tutor for Medicine from September 2018 to December 2021, I had a unique opportunity to collaborate with senior clinical and operational leaders along with educationalists. I was responsible for supporting the exit flow from the Emergency Department while providing trainees with the best possible support. I focused on three areas for improvement:

1. The process to review medical patients on surgical wards was through a medical locum consultant with trust-grade doctors in 2018.
2. There was a need to develop a model for covering a high number of medical COVID patients in surgical wards because of the impending COVID-19 pandemic in March 2020.
3. Locum staff gave notice to cover two escalation wards in February 2022. Despite considerable efforts to re-appoint locum consultant staff, this was not possible because of the high demand for their services.

Aims and objectives of the research project or activity The key aims of the activity were:

1. Improve patient safety
2. Improve quality of care
3. Improve productivity

The Royal College of Physicians' guidance on Safe Medical Staffing July 2018 sets out the number of medical staff that could safely care for patients on medical wards. The report recommended medical time to provide safe care for 30 beds was 71 hours of Tier 1, 30 hours of Tier 2 and between 20.5–24.5 hours of Tier 3 ward work. The wards at Medway Maritime Hospital were typically between 18–27 beds, and the cumulative medical staffing time exceeded the safe medical staffing hours recommended in this document. This became the foundation for expanding the performance of medical teams by adopting other areas of responsibility, not just their base medical ward.

However, when the demand exceeded the capacity, other activities were canceled to provide additional medical time to meet clinical needs.

Method or approach I took a continuous PDSA approach to this work with cycles of small change. The activity was undertaken through a collaborative approach and included all leads and stakeholders through regular meetings to receive feedback and constructive criticism, which led to further change. The Clinical Director's weekly meeting and Monthly College Tutor Team meeting became the driving force for change. In addition, proposed plans were shared with the Clinical Council, management and Executive colleagues and amended accordingly.

We met with our business partners and clinical and operational leads to review the number and grade of medical staff in each medical ward and daily reviewed staffing.

The number of medical patients was recorded on each surgical ward between 2018–2019. Furthermore, the number of total and medical admissions from the emergency department was recorded. The number of COVID patients and their location was recorded on a daily basis over the pandemic.

Findings 1. A system of ownership through medical-surgical paired wards.

Ward	Team	Acute Frailty (index score >5)
Phoenix	Gastroenterology	Milton
Arethusa	Lister	Tennyson
Kingfisher	Endocrinology	Byron
Pembroke	McCulloch	Orthogeriatric Team
Victory	Sapphire	Harvey

2. Average number of medical patients on surgical wards comparing locum activity (2018) to departmental ownership model (2019)

January	February	March