The RCP chief registrar scheme
2017/18 yearbook
Foreword

Over the past year I have been hugely impressed by the achievements of our chief registrars. Every year a new cohort has the chance to take on a vast range of projects and this year has been no exception, as they respond to local challenges and improve outcomes for patients, teams, services and organisations.

For the chief registrars themselves, the impact has been remarkable. Chief registrars have developed greater self-awareness as leaders, gained senior level experience that better prepares them for consultant posts, and have felt empowered to lead and support positive change. That is not to say that there have not been challenges, but through peer support and learning from the RCP development programme, chief registrars have developed and implemented strategies to overcome the barriers they have faced.

For this yearbook, each chief registrar has been asked to choose one project to highlight, but there are many others underway, at varying degrees of completion. The projects showcased here reflect the diversity of chief registrar activities and, importantly, demonstrate the autonomy and flexibility that are crucial factors in the success of the role, as highlighted in the 2017 independent evaluation by the University of Birmingham.

Morale and engagement has been a big focus of their role. Many have invested time and effort in understanding the specific local issues underlying low morale in order to inform programmes of work aimed at tackling these issues. For example, by easing workloads, resolving rota issues, introducing new roles and improving training opportunities.

Throughout their projects, chief registrars have demonstrated a commitment to ensuring trainees have access to quality education and training opportunities. In some cases the aim has been to ensure trainees have sufficient opportunity to fulfil formal requirements, while in other cases the focus has been on improving peer support, mentoring and non-clinical skills. This investment in the wellbeing of our trainees will support better recruitment and retention in the future.

Chief registrars have continued to play a key role in service and quality improvement. Some have led projects that are achieving significant cost savings through reducing inappropriate use of resources, reducing locum spend or reducing admissions. The benefits for the wider workforce are also evident; providing a bridge between senior clinical leaders, management and the wider trainee workforce means chief registrars are a valuable facilitator of staff engagement and collaboration for quality improvement across traditional silos.

The RCP is proud to have supported and played a role in developing this cohort of future clinical leaders, and we look forward to keeping in touch and hearing about their future successes.

Professor Jane Dacre
President, Royal College of Physicians
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Abigail Ash

Organisation: Royal Berkshire Hospital NHS Trust
Grade: ST6
Specialty: Acute internal medicine and general internal medicine
Mentors: Dr T McErlane, Dr J Lippett and Dr G MacDonald

One of the most enjoyable, stimulating and rewarding years; a chance to grow and develop in ways I probably have not even recognised! I have learned by apprenticeship, immersing myself in projects and conversations across the hospital. It has been challenging to listen and think about tackling the problems we (and the broader NHS) face, but I have had the opportunity to collaborate with clinical and non-clinical staff that I may not otherwise have encountered. The fact that the chief registrar role is embraced by my peers and at executive level demonstrates how vital the role is to help deliver sustainable change.

Ambulatory care: to bed, or not to bed?

Aim: To improve patient access to ambulatory care and increase the number of same day discharges (SDDs).

The ambulatory care service was relocated from a ward bay area in the acute medical unit (AMU) to a purpose-built unit ambulatory emergency care unit (AECU), in November 2017.

Stage 1: Stakeholder engagement
AECU cannot accommodate patients requiring overnight admission which meant changes to working practices and operating procedures were required.

Listening exercises were undertaken to understand stakeholder perspectives. I regularly met with members of the trust executive and operations team and facilitated an ‘away day’ for front door clinicians to discuss the impact of relocating AECU. I also visited other ambulatory care services to identify and incorporate areas of good practice.

Stage 2: Planning and relocation
To ensure proper functioning of the new AECU, I developed a new standard operating procedure alongside mapping and streamlining other clinical pathways within the hospital. The impact on IT, switchboard, estates, workforce, pharmacy and radiology was also assessed.

Stage 3: Collaboration
Several projects ensured collaboration between teams: in-reaching of the acute medicine consultants (APs) to the emergency department, and APs offering a direct telephone service for GP referrals. I led a team of junior doctors to analyse the medical clerking process and streamline our clerking process. We have also focused on using data and measurement to drive change.

Since relocation:
> the number of SDDs for AECU has increased monthly, compared to the same time period one year ago (greatest increase being 82 SDDs in January 2017 vs 188 in January 2018).
> there has been no increase in incident reports, serious untoward incidents or complaints.

Patient feedback has been consistently positive.

The relocation of the ambulatory care unit and the catalyst this provided for wider system changes has enabled patients to access ambulatory care and ensure they are seen in a more appropriate care setting. There are now new challenges to face to ensure the service continues to grow and develop.
Zoe Burton

Organisation: Portsmouth Hospitals NHS Foundation Trust  
Grade: ST7  
Specialty: Anaesthetics and critical care  
Mentor: Dr L Millard

My chief registrar role has provided an exciting and unique opportunity to benefit from bespoke leadership and management training. I have learned a new language, equipping me with key skills and tools to confidently initiate positive change. I have been empowered to actively promote the values junior doctors bring to innovation, unlocking communication channels with senior management. Reflecting on challenges and successes, I have been surprised and often frustrated by the protracted nature of leading change. I have gained improved recognition of personal strengths, and by putting leadership theory into practice, have built relationships and learned the importance of engaging others.

A little less conversation, a little more high impact action
Co-author: Helena Edwards, co-chief registrar at Portsmouth Hospitals NHS Foundation Trust

Aim: To improve the working environment for junior doctors.

NHS Improvement’s _Eight high impact actions to improve the working environment for junior doctors_ has provided a framework for the majority of the improvement initiatives we have implemented as chief registrars.

We conducted a cross-specialty survey to identify issues threatening doctors’ efficiency and enjoyment in their clinical roles. A monthly junior doctor (JD) forum gives JDs an opportunity to raise issues or concerns and present their ideas for innovation. Ideas were developed and presented to trust executives under the umbrella of the _eight high impact actions_. Each action has been progressed to varying degrees of completion.

Suggestions for improvements and efficiency savings ranged from better IT solutions, printed blood bottle labels, bleep-free communication and improved access to clinical guidelines, to seeing the chief executive ‘on the shop floor’, and encouraging better dialogue between management and frontline staff. 62.2% stated they had difficulty accessing trust clinical guidelines and 81.6% believed a smartphone app would be beneficial.

We have taken on a large number of projects, some of which are difficult to measure success. Others will take time to come to fruition, reflecting challenges we have encountered. The JD Forum, Paired Learning and Lessons Learnt programmes have been particularly successful with regular attendance and positive feedback. While the introduction of the clinical guidelines smartphone app has encountered multiple setbacks, an app platform has been funded, a governance system agreed, and a quality improvement package designed to support JDs in reformatting guidelines prior to app upload.

During our time as chief registrars we have received excellent support from senior management, which has helped pave the way in initiating changes in practice and culture. Remaining in clinical practice has enabled us to understand the complexity of difficulties encountered by both JDs and senior management.

One of the most valuable aspects of our role has been to give JDs a voice by providing a two-way clinical-managerial communication channel.
How do you improve a well-performing trust you have never worked at before? This was the question at the start of my role in December. So far I sense a strong willingness to improve practices among juniors in a culture that emphasises quality improvement. The key ingredients are here, so the next step is putting ideas into action. A chef cannot create a dish without knowing how the kitchen works, so I am learning rapidly about management structure and working collaboratively with colleagues to improve care. I hope to use my new knowledge to motivate others to become enthusiastic about quality improvement.

Learning from every death on an acute ward
Co-authors: Sundas Hasan, Mohammed Soliman, Carlo Prina

Aim: To generate learning points from a review all deaths on an acute medical unit.

The process of formal mortality review on the acute medical ward started in 2015. There were a total of 122 deaths between April 2015 and September 2017, all of which were formally reviewed using a standardised structured assessment form. The form was completed by a junior doctor who was involved in the care, followed by the responsible consultant. This was then evaluated by an independent consultant and finally peer-reviewed in our quarterly mortality meeting. We used the confidential enquiry into sudden death of infants (CESDI) score to numerically document whether there was harm in each case. Learning points were generated where areas of potential improvement were identified. These were regularly presented to the multi-disciplinary team to discuss and create action plans, to improve future care.

Common learning themes emerged, all of which highlight the importance of early interventions such as timely discussion regarding treatment escalation plan (TEP), early recognition of the deteriorating patient, and prompt initiation of palliative care plan where applicable.

Following the first mortality meeting, we also measured the completion rates of TEP during inpatient admissions for 12 months and repeated this for the equivalent period in the following year. We found there had been significant improvement in the completion rates of documented TEP. For example, the documented TEPs for all acute medical admissions from October 2015 to September 2016 improved from 7.5% to 18.3% in the subsequent year.

We recognised the challenges in establishing a formal mortality review process but achieved this by creating an open and honest culture and encouraging objective review of all deaths. This process has also created an environment where we can confidently review each other’s delivery of care. We invite regular feedback to improve this process.

An overwhelming majority agreed that this has led to improved awareness in end-of-life care and a more ‘blame-free’ culture.
Michelle Cooper

Organisation: Warrington and Halton Hospitals NHS Foundation Trust
Grade: ST7
Specialty: Acute internal medicine and general internal medicine
Mentor: Dr K Clark

During my tenure as chief registrar I have completed many projects including the introduction of an acute internal medicine follow-up clinic that has facilitated early discharges and anecdotally reduced length of stay. I have faced many challenges, but through personal and professional development as a result of the chief registrar development programme I have acquired essential skills to overcome these. Consequently I will commence my consultant post with an improved understanding of how to develop services, manage people effectively whilst understanding the motivation behind their behaviour, and lead a team with both confidence and the ability to achieve the desired outcomes.

Acute medicine clinics: the pathway to earlier discharge?

Aim: To improve patient flow by facilitating early discharge.

In light of current bed pressures, I implemented a new urgent access acute medicine clinic to provide an alternative avenue to admission for patients. The clinic allows early outpatient review (within days to weeks) to review symptoms and outstanding investigations. Patients are given appointments following review or discussion with the medical team (registrar or consultant) by the emergency department (ED) or other specialties. Additionally GPs can access appointments following discussion with the medical registrar on call. Currently, there are 20 appointments per week, with a plan to expand this to 32 in the coming months.

The survey showed that the vast majority (93%) of doctors felt that the introduction of acute medicine urgent access clinics has resulted in expedited discharges from the acute medical take. Other results showed that:
>
77% believe the clinic has helped expedite discharges from ED who otherwise would have been referred for admission under medicine
>
79% believe the clinic has helped expedite discharges from the post-take ward round
>
87% believe the clinic has helped expedite discharges from the acute medical unit (AMU).

Less than 1% of patients have required admission directly from the clinic, demonstrating that patients are being selected and managed appropriately for review as an outpatient in the acute clinic. Clinical case review estimated 151 bed days saved in 1 year with a predicted cost saving of £37,750 to the trust without incurring any extra expenditure. A patient survey demonstrated a median average of 10/10 for satisfaction. The plan is to develop the clinic further to expand the number of appointments offered and open these up to direct GP access to divert suitable medical patients from ED to a clinic setting.
Helena Edwards

Organisation: Portsmouth Hospitals NHS Trust
Grade: ST5
Specialty: Nephrology and general internal medicine
Mentor: Mr S Holmes

My experience as chief registrar has been rewarding and deeply insightful. My focus this year has been on improving the working lives of junior doctors, providing a direct link to the managerial team and facilitating innovative projects led by junior doctors themselves. Implementing change requires planning and involvement of the right stakeholders; it demands both time and perseverance before the rewards become apparent. This role has consolidated my belief that investing in junior doctors’ wellbeing is important to the future success of the NHS. Moving forward, I now have the skills to facilitate and direct the valuable contributions of junior doctors.

Lessons Learnt programme

Aim: To improve awareness and recognition of patient safety incidents, to engage junior doctors in the process of incident investigation, and to promote learning and a no-blame culture.

Junior doctors are at the frontline of clinical medicine and are regularly exposed to patient safety incidents (PSI). Despite this, it is well recognised that a large number of PSIs go unreported, and that junior doctors are low reporters.

The Lessons Learnt programme is a patient safety training programme where trainees lead a peer-group discussion and analysis of a PSI in a safe, facilitated forum. The programme was originally developed in North Western Foundation School and has been evaluated comprehensively with high satisfaction rates. I led the introduction of this programme for all foundation year 1 (FY1) doctors in my trust.

As part of the programme an introductory session was held in December 2017 which included collection of a pre-programme questionnaire to evaluate FY1 trainees’ understanding and experience of PSIs.

Twenty-two FY1 doctors completed the pre-programme questionnaire. Findings revealed that 86% stated they had witnessed a PSI, but only 28% had completed a safety learning event form.

59% were confident in identifying an incident, but only 32% understood the root cause analysis process.

A monthly 1-hour session was integrated into the mandatory bleep-free foundation teaching programme. In each session, a FY1 volunteer to present a patient safety incident they have encountered, and this forms the basis for a facilitated small group discussion. The discussion is structured to follow a shortened root cause analysis process, focusing on the lessons learned and actions that can be taken.

The programme has also encouraged trainees to initiate quality improvement projects following the discussions.

Feedback received from participants so far has been good to excellent. Trainees have been keen to volunteer to present a case, with a variety of PSIs discussed. The sessions provide them with an opportunity to be formally assessed on their teaching skills, by giving a presentation and then leading a discussion with their peers, contributing to their ePortfolio.
As chief registrar I worked with a team to develop a solution to medical registrar on-call rota gaps by incorporating the general medicine and elderly care weekend registrar cover into a single rota. Previously, medical and elderly care patients had separate registrars for weekend day cover. I was tasked with assessing the effect of this change.

The trust has been significantly affected by reduced numbers of higher medical trainees entering elderly care and general internal medicine. We have seen increasing numbers of medical on-call rota gaps, with the obvious implications for patient safety. To cover these gaps the trust often has to turn to locum cover with the consequent financial implications. Further pressure was caused by the number of filled posts falling further following registrar rotations in spring 2018.

It was therefore important to understand the effect of rota changes. A 6 month period prior to the change was analysed and post-implementation data is still being collected. Findings showed that prior to the introduction of the combined rota:

- there were 11.5 FTE registrars for an equivalent of 14 positions (82% fill rate), due to reduce to 8.5 FTE (61% fill rate) following the February/March 2018 rotation.
- before the rotation there was a mean of 8.7 unfilled medical on-call registrar shifts per month. The cost of covering these locum shifts at standard registrar rate would equate to £6,264 per month, not accounting for enhanced rates for antisocial hours or locum agencies
- following the rotation this would have increased to a predicted 19.1 shifts per month requiring cover at a cost of £13,752 per month.

There appears to have been a reduction in the number rota gaps requiring cover, with associated reduction in financial cost.

The implementation of the new combined rota was essential to ensure sufficient senior medical cover at weekends, both for patients and junior doctors. To date, there appears to have been a reduction in the number of persistent rota gaps requiring cover, with associated reduction in financial cost.
Anna Farris

Organisation: University Hospital Southampton NHS Foundation Trust
Grade: ST6
Specialty: Emergency medicine
Mentor: Dr J Mountfield

The chief registrar role has been excellent for exploring interests in medical management, education, quality improvement and service development, while still maintaining a clinical presence. It has formalised the voice of junior doctors when communicating with senior hospital executives, which has been welcomed by my trust. The RCP chief registrar development programme has been a great portal for sharing ideas with chief registrars from multiple specialties around the UK and potentially influencing positive change in multiple organisations.

Engaging junior doctors in our trust’s medical leadership and management

Aim: To increase awareness of the importance of good leadership and senior hospital executive roles among junior doctors, in order to improve engagement and promote development of future clinical leaders in the NHS.

A 1-day event focusing on leadership and management for senior registrars was organised. The event was open to senior registrars (ST5 and above) in all specialties at University Hospital Southampton, a large university teaching hospital and tertiary referral centre. Speakers were specifically chosen from senior trust executive staff and the senior consultant body to talk about relevant aspects of healthcare management and leadership, and their career pathways.

89% reported the event had improved their understanding of leadership and management roles.

More than 70 delegates attended the event at which 10 senior hospital staff presented. Speakers included the chief executive officer, the medical director, the chief financial officer and the chief operating officer.

Feedback was sought from attendees on their satisfaction with the course content and understanding of leadership and management as a result of the course. Of those delegates completing feedback, 95% rated the content as good or excellent, and 89% reported the course had improved their understanding of leadership and management roles in the hospital.

There is an appetite among registrar level doctors for leadership and management training and engagement with senior executive staff. There is also appetite from the trust to make this an annual event as the trust values the contribution junior doctors can make. This training will better equip future consultants in their leadership roles and furnish them with tools to navigate management meetings. Further courses are planned to address this locally as a result of this successful training day.
Gary French

Organisation: East Sussex Healthcare NHS Trust
Grade: ST7
Specialty: Geriatric medicine and general internal medicine
Mentor: Dr S Merritt

The role as chief registrar has been a highly educational and challenging experience. I have learned to manage my time more effectively and to meet and engage with a broad spectrum of people who are central to the running of a hospital. Providing a link between trainees and senior hospital staff and reconciling opposing viewpoints has been challenging. The role has made me appreciate the importance of effective leadership and management in running an efficient service. I hope that the skills and experience I have gained during this year will assist me in becoming an effective clinical leader as I move towards completing my training and beyond.

Identifying frailty at the front door

Aim: To harness the work already done by the community frailty team in establishing advanced care plans for frail care home residents. Identifying patients with these plans at the front door to ensure clinical teams can be best placed to deliver care which is tailored to the patient's own wishes.

East Sussex Healthcare NHS Trust has a large elderly population. These can be complex patients with several coexisting co-morbidities. As a geriatrician I am aware that the acute hospital environment is not always the most appropriate or preferred place of care for many of these patients. There has been an increased move for health care providers to provide frailty input at the front door of hospitals.

The trust already has a nurse-led frailty team who visit patients who are highlighted as being frail in the community to undertake a comprehensive geriatric assessment and discuss advanced care planning. It is hoped a more joined-up service involving the frailty team working in both the community and acute settings will lead to enhanced care for our frail patients.

Admissions to the Conquest Hospital under the elderly care take were reviewed over a 4 week period to identify those patients who had been admitted with an existing advanced care plan in place. Notes were reviewed to see if this care plan had been documented and acted upon. A pilot triage form for the emergency department and acute assessment unit will be issued to prompt staff to check and document if an advanced care plan is in place. Results are awaited at time of submission.

We hope to show that early identification of existing advanced care plans can guide the care given to patients by their medical team and aid in patients’ wishes being met.

A more joined-up service involving the frailty team working in both the community and acute settings will lead to enhanced care for our frail patients.
Susan Hayward

Organisation: Salisbury NHS Foundation Trust
Grade: ST6
Specialty: Anaesthetics
Mentor: Dr C Cox

I feel it has been important to support all specialties, and other staff, because morale is affected by many complex interactions. I have joined projects at varying stages of progress and initiated others. I have stepped up to the responsibility and had the opportunity to develop in multiple ways including through local courses in coaching skills, resilience training, and an innovators business development course. I lead on collaborative projects in Wessex, have linked with national projects, and invited myself to visit British Airways and Deloitte to learn from other industries.

Sharing Outstanding eXcellence (SOX)

Aim: To recognise and understand positive events, with the concurrent aim of improving morale.

We are encouraged to report negative events, and changes to practice are made based on learning from negative events, but most of the time things go well – and we rarely stop to consider why they did. 57% of staff agreed that they learn from negative events, but only 28% of staff felt they learn from positive events.

The SOX initiative offers an opportunity for anyone to nominate staff for excellence by asking ‘what did they do that was excellent?’ Nominations are sent to our quality lead, then to the recipient and their line manager. The system was piloted on a single ward and rolled out with the target of implementing SOX across the trust.

Benefits are expected in three areas:

➤ The recipient is rewarded and has a chance to reflect and learn.
➤ The trust is able to learn from the overview of themes and make improvements.
➤ The nominator is encouraged to look for examples and recognise good practice, which brings with it a more positive culture.

The initiative has been welcomed by staff and management teams, and a regular and increasing influx of SOX reports is received. Quality improvement methodology has allowed questions to be refined to improve helpful information.

In the pilot, 93% agreed that SOX reporting had improved staff morale. Those that had been nominated reported feeling ‘appreciated’, ‘boosted confidence’ and ‘fantastic’. Early measures show a self-reported increase in learning from positive feedback from 76% to 93%. Staff agree that the initiative should continue.

Positive event reporting can benefit staff morale, engagement and patient safety. This change is a simple one that has the potential to be a powerful agent for change.
In the current busy climate, we focus on delivering quick and safe care. However, is this sometimes at the expense of recognising patients as individuals with lives outside the hospital, and ensuring they are kept informed? My vision is to give patients more opportunities to tell us what is important to them while in hospital, and improve their understanding of what their hospital stay will entail. I aim to improve patient satisfaction scores on one of the acute wards by 10%, relating to how well patients feel they have been listened to, how well informed they have felt, and how well they have felt their individual needs have been addressed.

I have trialled a variety of means to ask patients what is important to them. I am currently distributing cards that say: ‘Tell us something about yourself which will help us to care for you’ with a section saying ‘I am not completely clear about:’ followed by tick boxes for ‘my diagnosis’, ‘my tests’, ‘my treatment, and ‘how long I am expected to be in hospital’. I have encouraged clinical staff to endeavour to address what is written on the cards, and explored satisfaction levels among patients both with and without cards.

Based on small numbers so far, mean scores relating to how well patients have felt listened to and how well patients have felt their individual needs have been addressed have been higher in the group that has received cards. However, the mean scores relating to how well informed patients have felt have been higher in the group that has not received cards.

All patients have felt that the cards are a good idea and the project has appeared to result in a small improvement in certain satisfaction scores. To improve these scores further will require a change in the wording of the questions on the cards, more effort to encourage patients to use the cards and ensuring staff respond to what patients are writing. The next step will involve trialling the cards in other clinical areas.
Jennifer Joiner

Organisation: Hampshire Hospitals NHS Foundation Trust
Grade: ST5
Specialty: Emergency medicine
Mentor: Dr L Alloway

For me, the real privilege of the chief registrar role is being able to dedicate half my working hours to projects I have chosen and designed. Navigating the operational side of a hospital provided a great challenge in the early stages and took some getting used to. I am now halfway through my tenure and feel more confident in my role, with a clear vision for what I want to achieve with my remaining time in post. I have come to strongly believe that investing in staff and their wellbeing is vital for improving healthcare quality and I want to focus on this moving forward.

Improving out-of-hours working

Aim: To improve out-of-hours care and improve junior doctor workloads.

Hospital at Night (H@N) is a well-established system of providing out-of-hours care to patients that has been shown to improve patient safety, reduce mortality and increase productivity. In 2018 my trust still had no formal system for out-of-hours working, causing unmanageable workloads for junior doctors, with repeated trainee surveys and the GMC highlighting this as a concern.

Stakeholder mapping was undertaken to identify key individuals to form a H@N working group. A series of meetings was held between these stakeholders to create the conditions for H@N. This included establishing baseline data by performing an audit of work undertaken by junior doctors out of hours; up-skilling the night practitioner cohort to take on the role of the H@N coordinator; re-designing the night practitioner rota; educating the nursing and medical workforce about the anticipated changes; designing possible IT solutions and drafting standard operating procedures to support H@N.

Following the launch of the new system, feedback was regularly gathered from all staff involved which was used to refine the process. A process of continuous data gathering and monitoring is now established.

Since the new system launched, the number of bleeps received by junior doctors out of hours has fallen from 48 to 15 (average) per night. The average time for a bleep to be answered has reduced by 75%. Across all specialties, doctors are spending a larger proportion of their time with unwell patients, improving patient care and safety.

Feedback from the junior doctors has been positive overall, with reports of increased productivity, feeling more supported at night and workloads being more manageable. Feedback has also revealed areas for improvement including robust planning for H@N coordinator sickness and protection of the coordinator role, better engagement of ward nursing staff and training for coordinators.

Implementing H@N has thus far had a positive impact on the workload of junior doctors out of hours.

Longer term data will be required in order to assess impact upon patient safety. Future developments include designing an IT system to support H@N, widening the system to run at weekends and implementing the system across the trust.
Fasihul Khan

Organisation: University Hospitals of Leicester NHS Trust
Grade: ST7
Speciality: Respiratory medicine and general internal medicine
Mentor: Prof R Green

The chief registrar year has undoubtedly been an enjoyable and steep learning experience. Frequently engaging with senior clinicians and managers, I have grown in my ability to identify, understand and address challenges. I have also gained significant insight into my leadership style. Change is often challenging, and I have learned strategies to navigate around difficult personalities and situations. The importance of aligning end goals with others to ensure maximal output has become apparent. I have become passionate and confident about quality improvement, resulting in sustained change. The skills gained during this opportunity will undeniably contribute immensely to my career.

Innovative solutions to medical workforce challenges

Aim: To reduce workload for over-stretched junior doctors and address rota gaps.

Junior doctors work shifts with increasing intensity often exacerbated by frequent rota gaps. A number of interventions are underway to aid the junior doctor workforce in our hospital.

Doctors in our department previously looked after patients across more than one ward. Often the ward with fewer patients was attended to later in the day, delaying clinical tasks, causing nurses to repeatedly chase doctors and doctors providing poor feedback. As part of a restructure, junior doctors were realigned into ward-based teams. Patients were split on the ward by consultant team, and junior doctors paired up with nurses to look after bays of patients, increasing continuity of care.

We are also piloting a new Band 3 doctor’s assistant (DA) role. The DA receives on-the-job training from junior doctors and thereafter helps with simple tasks such as discharge letters and chasing scans, as well as assisting with clinical skills such as venepuncture, cannulation and catheterisation. This role will enable junior doctors to concentrate on spending longer with patients, thereby enhancing training.

To aid rota gaps, we have created two novel FY3 level posts to attract trainees who wish to undertake further experience before embarking on specialty training. The first is a 50% clinical, 50% leadership role which offers protected time to carry out quality improvement and educational projects. The FY3s have made excellent progress thus far. The other FY3 role involves three rotations of four months each, one of which is a ‘sabbatical’ period in which doctors are able to pursue other interests.

A junior doctor referral toolkit has been established on the hospital intranet website. The toolkit provides junior doctors with referral guidance for most hospital specialties and includes contact numbers. This toolkit will reduce long switchboard waits and also give junior doctors more confidence in referrals.

Anecdotal feedback from these interventions has been extremely positive: 95% of trainees said they would recommend their post to a colleague.
CMT clinic access
Handover
Procedural bleep
Working conditions
Induction
Ensuring fair pay
Junior doctor wellbeing and morale
Learning from excellence
Recruitment
Patient flow
Service improvement
Safe medical staffing
Junior doctor awards
Improving rest facilities
Lecture series
Junior doctor’s mess
Improving communication
Medical admissions
Grand rounds
Nottingham University Hospitals is suffering from significant junior doctor rota gaps; a result of the imposition of the new junior doctor contract, poor recruitment to core medical training and an increasing trend towards trainees taking a career break following completion of the foundation programme (58% in 2017). These gaps are impacting on training opportunities and trainee morale, and are leaving wards short staffed, resulting in increased reliance on locum doctors, particularly out of hours.

We identified 1,286 gaps in the foundation doctor and core trainee rota over 12 months, equating to around 10,000 hours. Only 52% of these gaps were filled with locum doctors, at a cost of nearly £900,000, with 72% of these shifts being out of hours. This is likely to be exacerbated by the removal of six core medical training posts in 2018.

We devised two novel non-training programmes aimed at trainees who have completed the UK foundation programme, who are likely to take a career break and who do not currently apply for established trust grade posts. These will incorporate:

- ‘Foundation year 3’ posts offering:
  - 8 months service provision paid over an annualised contract (creating an effective 4 month paid sabbatical)
  - protected half day training time for a special interest and study budget
  - flexible hours and option to contribute 60–100% to the on-call rota.

- Hospital at Night posts offering:
  - one week per month protected non-clinical time for service development
  - flexible out-of-hours working aimed at covering current rota gaps
  - study budget and annual leave.

We will measure the success of this programme by assessing the total number of applicants and competition ratios, the percentage monthly decrease in rota gaps and locum spend, and subjective feedback.
Jonathan Mamo

Organisation: Solent NHS Trust
Grade: ST6
Specialty: Rehabilitation medicine
Mentor: Dr D Meron

The chief registrar scheme has given me the best possible platform to learn, through experience, about management and leadership within the NHS. I have been exposed to new methods of thinking about complex problems through simple techniques used in other industries. There have been opportunities to learn the language and skills of management to facilitate interaction with managerial and leadership staff in the NHS. Being given the responsibility of balancing clinical work with the chief registrar workload has been excellent preparation for future consultant posts. The scheme has given me greater confidence, which I hope to develop further as a consultant.

Establishing safe transfers between acute medical and psychiatric inpatient facilities

Aim: To improve communication between two hospital trusts at the pre-transfer phase, thereby ensuring safe transfer of medically fit individuals to a psychiatric hospital.

The transfer of patients from acute hospitals to psychiatric inpatient facilities requires clear communication and careful coordination of care in order to maximise patient safety. Anecdotal evidence suggests handover information at transfer is variable. This has sometimes resulted in patient safety concerns, and it is felt that there is a need for an established standard.

A simple to follow, one-page form ensures appropriate documentation of requested status.

The results of the questionnaire were followed by the introduction of a pre-transfer medical checklist. Designing the checklist and guideline required doctor-to-doctor discussion across the two sites to ensure the minimum medical criteria for safe transfer to a psychiatric bed were agreed and confirmed. A simple to follow, one-page form was created to ensure appropriate documentation of requested status.

The checklist went live once stakeholders had an opportunity to contribute to its creation. Following a trial period, we collected data from all adult and old patient transfers from regional acute hospitals to psychiatric units in Portsmouth, establishing the level of checklist completion and acquiring feedback from parties involved. The feedback has been generally positive with more detailed results being collated.

In establishing a standard for transfer of care, we hope to safeguard the safety of our patients and instil confidence in health care professionals involved in their transfer.

RCP chief registrar yearbook 2017/18
Inpatient referrals to medical specialties at Kingston Hospital are done in many ways with no unified system. Different specialties use paper forms, magnets on whiteboards, phone referrals, Excel spreadsheets or even the fax machine. The highest volume of inpatient referrals to all medical specialties is from the acute assessment unit (AAU).

By creating a standardised electronic referral system, a referral can be made from – and reviewed by – the specialty team from any computer in the hospital. A triage system will be trialled to enable specialty teams to prioritise the order of referrals by urgent, routine or telephone advice only. We hope to improve efficiency when referring patients, become paper free and reduce the number of bleeps and re-referrals made when the status of a referral is unknown. This system will also allow referrals to be more visible and improve the ability to audit them.

Junior doctors on AAU were surveyed about their current experiences of specialty referrals and suggestions were made as to how the system could be improved. An electronic referral form was created, along with an outcome form for specialty teams to complete. These are synchronised with the electronic patient record system, enabling referral information to be viewed on the patient’s notes.

Respiratory and cardiology have the largest volume of referrals and are participating in the pilot scheme. Rigorous testing of this process was carried out with ‘test’ patients in the dummy electronic patient system. This enabled a real-time view of how referrals could be made and completed, identifying issues along the way.

The start of the pilot study has been publicised via the grand round, email and with notices in the clinical areas. If the use of electronic referrals proves to be successful it will be rolled out to other specialties in the hospital. Full conclusions will be available once data from the pilot scheme has been analysed.

**iReferrals: time the referrals got intelligent**

**Aim:** To improve the efficiency of the inpatient referral process to medical specialties.
Making handover better

Aim: To improve medical handover.

The handover process has been identified as an area requiring improvement by both staff and the CQC. As chief registrar, I was asked to identify problems with and to improve the on-call handover process within the medicine department.

First, an online survey was sent to all junior doctors participating in the on-call rota, as well as nurse practitioners and coordinators from the Hospital out of hours team. Questions were included about the timing, leadership, documentation, effectiveness and safety of the daily morning and evening handovers. The survey also asked respondents to provide suggestions for improving the handover process.

The survey received 35 responses across different grades of staff. In general respondents were satisfied with evening handover, although only 37% felt it was standardised and consistent and 23% felt it was documented appropriately. Results for morning handover were less satisfactory. Only 41% felt that there was a formal handover meeting in the morning. 67% had difficulties identifying the correct colleague to handover to and 56% felt that there was no standardisation. Worryingly, only 32% agreed that morning handover was safe.

In the free text responses, many respondents identified that there is no overlap between shifts in the morning and no embedded culture of a morning handover meeting. When asked for a preferred solution to this there was no overwhelming preference, but the largest percentage (33%) wanted the base ward specialties to send a representative to take handover on behalf of their wards – these people would arrive 15 minutes earlier than previously to allow shifts to overlap.

The survey confirmed the generally held belief that the handover process needs improvement in order to bring it into line with the recommendations made in the RCP's Acute care toolkit 1: Handover. It also helped to identify the most acceptable solutions to the problems presented by shift patterns. The new handover process has been agreed and is due to commence with the new rotation of doctors. At a later stage the survey will be repeated, the results compared, and adjustments made as necessary.

Being a chief registrar has been challenging, but ultimately the most rewarding time I have had during my career as a doctor. I have valued having both time and resources to lead quality improvement (QI) initiatives and am pleased that I am making lasting change within my organisation. The skills that I am gaining in QI, leadership and management, as well as greater knowledge of NHS structures, will stand me in good stead as a consultant. I am looking forward to new challenges, confident in the skills I have developed over the past months.

Emily McNicholas

Organisation: Sheffield Teaching Hospitals NHS Trust
Grade: ST6
Specialty: Geriatric medicine and general internal medicine
Mentor: Dr J Hill
Christopher Mitchell

Organisation: University Hospital Southampton NHS Foundation Trust
Grade: ST8
Specialty: Trauma and orthopaedic surgery
Mentor: Dr I Simpson

I initially found it unnerving to be offered the opportunity to develop my role in a way I chose, but this actually allowed me to be responsive in identifying key areas to address. Remaining flexible with my chief registrar time also permitted me to support my department during periods of increased clinical demand. My particular focus has been junior doctor wellbeing; I have also looked at streamlining patient flow through ‘SAFER’ rounds and improving patient experience. I have learned to balance the pressures of my clinical and leadership/management roles with family life, and gained confidence during senior management interactions – all invaluable skills for an orthopaedic consultant.

Could it be you? The impact of a medico-legal awareness event

Aim: To improve junior doctors’ understanding of legal issues.

In the wake of the Dr Bawa-Garba case, there is now a heightened level of anxiety around medico-legal issues. An evening lecture session for doctors, harnessing local expertise, set out to clarify:

1. legal principles surrounding gross clinical negligence manslaughter and the Dr Bawa-Garba case
2. the trust’s stance with regards to resource-pressured working
3. potential legal issues of reflective practice
4. what happens during a GMC Fitness to Practise investigation.

The evening was also intended to dispel a number of the myths surrounding legal issues underpinning the Dr Bawa-Garba case and the potential vulnerability of junior doctors to similar consequences in the face of systemic failings and increased clinical pressure.

Interactive lectures were given by:

> an experienced consultant surgeon who had been through GMC Fitness to Practise proceedings.

More than 70 clinicians attended the medico-legal issues evening; feedback was obtained from 16 of these, outlining their understanding of the issues covered both pre- and post-event.

Following the medico-legal issues evening, attendees reported a significant increase in their understanding of the principles covered. The greatest increase – of 63% – was seen in relation to Fitness to Practise investigations, followed by medical law underlying gross clinical negligence manslaughter at 56%, trust stance with regards resource-pressured work at 31%, and reflective practise issues at 19%.

Although higher medical and surgical training programmes develop the clinical skills of doctors, little time is dedicated to the processes that result if an adverse event occurs. This teaching session addressed a significant need in the clinician cohort, resulting in significantly increased understanding of principles surrounding medical law, GMC proceedings and reflective practice.

Similar sessions should be held in trusts across the country, making use of local expertise to increase clinicians’ understanding of these important issues, and demonstrate local support for the invaluable role junior doctors perform.
Kirsty Nelson-Smith

Organisation: Great Western Hospitals NHS Foundation Trust
Grade: ST4
Specialty: Geriatric medicine and general internal medicine
Mentor: Dr C Mackinlay

My role as chief registrar has given me a unique insight into how a hospital runs and is managed, and has provided me with the opportunity and time to develop a new service. I have learned about differing leadership styles in both theory and practice, and about negotiation. The main challenge has been planning my time, but learning how to say ‘no’ has helped with this. I intend on taking this experience forward into future roles, hopefully a leadership capacity, but also utilising it in service development projects in the future.

Hospital at Night

Aim: To improve patient safety, junior doctor training, and nursing training, development and retention by introducing a hospital at night service.

National data shows that Hospital at Night services make clinical care safer and locally there is evidence of the need for improving patient care overnight. In addition, improvements to junior doctor training and support are required as per deanery mandate and exception reports.

The new service will improve efficiency of overnight clinical work, with additional staffing and different ways of utilising clinical staff and IT systems. We also aim to improve nursing training, development and retention by providing opportunity for nursing progression within the advanced clinical practitioner (ACP) model.

We have been running a pilot with the ACP role in place, and the next stage is submission of business case for trust review.

The pilot has shown a reduction in ward-based workload for medical doctors. The pilot has shown a reduction in ward-based workload for medical doctors.

Initial data was collected and services elsewhere were reviewed to determine what is needed at Great Western Hospital (GWH). We have used a multipronged approach to the project by introducing an ACP role who will coordinate the hospital at night, and also an IT solution to triage tasks and remove the need for bleeps overnight. The doctors will work differently to provide more flexibility and cross-cover of specialties as needed.

Hospital at Night is needed in GWH for multiple reasons and the pilot is making good progress in improving patient safety and reducing time taken to provide clinical assessment. Work is ongoing and pending the outcome of the business case, more conclusions can be drawn at that time.
The background to this project was a growing district general hospital reliant on an increasingly outdated system of paper notes, drug charts and separate departments with idiosyncratic requesting procedures. Processes were cumbersome, non-auditable and open to systemic error.

The eCare solution will amalgamate systems into single, auditable patient records, accessible from any trust computer, solving issues with legibility and accountability. The trust will be equipped with a system fit for the digital age and its growing population.

Our challenge was to train an entire hospital of healthcare professionals on eCare prior to the ‘go live’ date in May 2018, and ensure all inpatient drug charts were transcribed on the transition weekend. As chief registrar I was tasked with two specific outcomes.

1. 90% of junior doctors to have completed training prior to the ‘go live’ date. This was a collaborative effort between doctors, medical staffing and transformation teams to ensure doctors could attend training without compromising patient care on the wards. The training sessions were for specific training needs, while grand rounds and audit half days were used to communicate the strategic vision driving the eCare project.

2. 100% of drug charts in the trust to be transcribed during transition weekend. Junior doctors were recruited from our existing staff pool to assist with drug chart transcription on the transition weekend at competitive locum rates. A bonus was offered to the doctor who transcribed the most drug charts.

The implementation of eCare was a transformational change affecting every healthcare professional in the trust. Doctor engagement was essential for its success. We used multiple approaches to win the hearts and minds of the workforce, while maintaining energy throughout the transition period.

We used multiple approaches to win the hearts and minds of the workforce, while maintaining energy throughout the transition period.
Junior doctor morale is at an all-time low. Our vision is to make our organisation an ‘island in the storm’ of medical training. To understand needs, we surveyed the junior doctors in our organisation, asking them to rate their satisfaction with their experience, identify positive and negative aspects of their working lives, and suggest priority areas for improvement. We combined this with information from the GMC National Training Survey and exception reporting data raised to the Guardian of Safe Working. We identified themes from this data as targets for improvement, and sense-checked these with a focus group of junior doctors from across the organisation.

We received a low, but acceptable, 20% response rate to our survey. 67% of respondents were either satisfied or very satisfied with their experience. 19% were dissatisfied or very dissatisfied and a further 14% gave a neutral response. Reasons for dissatisfaction were unsurprising: workload and the impact of workload and service demands on training, rotas and access to leave, culture and attitudes towards junior doctors and their training, facilities and environment, and difficulties with induction, contracts and payroll.

With the support of the executive team we have developed a number of trust-wide projects to tackle these problems which are delivering sustainable improvements in junior doctor experience. These include: creating appropriate rest facilities for out-of-hours teams and separately improving the doctors’ mess, setting up HR and payroll drop-in sessions to deal with contract and pay issues, improving junior doctor induction processes, developing a training programme for rota coordinators, and developing a ‘good practice guide’ to help services improve culture and attitudes towards junior doctors and their training.

We have developed a number of trust-wide projects which are delivering sustainable improvements in junior doctor experience.
Current attrition rates experienced by the acute medical specialties has been a cause for concern over the last few years. Without adequately investing in and supporting our trainees, this is likely to continue.

Survey results conducted in our local trust concluded that up to 40% of our trainees were considering a break or not proceeding on to ST3 at all. Delving into the root causes of this, we found that a lack of support and careers advice, and poor morale, were contributory factors.

To address this gap, each of our core medical trainees was paired together with a specialty registrar of their choice in their corresponding specialty of interest. The aim of the mentorship programme is to provide support for trainees undergoing specialty interviews. Mentors were able provide assistance and guidance for portfolio development, interview preparation and overall clinical support.

Mentors were encouraged to meet with their mentees at CT2 level on at least a fortnightly basis to provide support and enhance development over a 4–6 month period leading up to interviews. For the CT1 doctors the mentorship programme would be implemented for longer.

In our current cohort of ten CT2 trainees, six were eligible to progress onto specialty training. All six have applied for higher specialty interviews giving a 100% progression rate. The remaining four trainees intend to progress once exam and portfolio obligations have been met.

Out of our current cohort of CT1s, all six are intending to apply for higher specialty training.

This project has shown that there is a place for in-house mentorship programmes in order to help guide our current core trainees onto higher specialty training. Mentorship can enhance interaction between various grades of trainee, help with applications and interview preparation, and ultimately improve morale. This programme can easily be implemented to cater for foundation year trainees progressing onto core training.
It is recognised that we are at our most observational, reflective and questioning in the first few days of being in a new environment. This is a time when we are most likely to identify opportunities to make improvements. Junior doctors, with their regular job rotations and unique experiences of the healthcare system, are ideally placed as agents for change but are largely under-valued and under-utilised.

The Francis Report in 2013 stated that junior doctors are the ‘eyes and ears’ of the NHS. By encouraging and empowering junior doctors to record their initial observations and supporting them with QI, we can have a positive impact on their engagement and morale while driving improvement forward.

A baseline survey was conducted to assess how well junior doctors working in the acute medical unit (AMU) feel they are involved and supported in QI and how well they feel they are listened to. Data was also collected regarding the number and characteristics of completed QI projects over the past year.

An online data collection application (FRESH EYES) was designed and produced for junior doctors to complete during their first week of their AMU rotation. Various industries have used the FRESH EYES concept to identify opportunities for improvement. Junior doctors will be invited to take part in the project on a voluntary basis. Participants will meet two weeks into their rotation in a focus group, and will be supported to work together to develop QI projects. They will further be supported with meetings every month for the remainder of their rotation.

A follow-up survey will be completed at the end of the rotation, as well as data collected about the QI projects undertaken. Results will be available in August 2018.

FRESH EYES: empowering junior doctors as agents for change

Aim: To encourage and empower junior doctors to engage in quality improvement (QI).

I used to be fearful of approaching important people. Now I just type emails, close my eyes and press send! Becoming a chief registrar has required me to have courage to step out of my comfort zone, try new things and accept that I will not always get it right. Through trial and error, great mentorship, and a more detailed understanding of the concepts of leadership and quality improvement I have got better at working out how to get things done, communicating with others and overcoming obstacles. And I have not regretted sending a single one of those emails!
I have always struggled with feelings of legitimacy when attempting change projects, despite my varied backgrounds in middle management and as chair of the trainees committee at the RCP. The chief registrar role and the position it provides in the host organisation gives explicit permission to intervene and make changes happen, as well as teaching one how to effect change. I now better understand how I can use and modify my personality traits to influence different personalities, while finally accepting myself as being a valuable member of the team (Marmite or otherwise). The chief registrar scheme has been my missing link; I am ready to become a consultant.

Passing the baton

Aim: To improve communication and culture around handover, increase training and assessment opportunities, and improve patient safety.

Handover at SASH only officially happened once a day, in the evening, and displayed silo working. It was constantly interrupted by attempts to refer new patients or emergency calls, and due to high workload, often overran into a Hospital at Night (H@N) meeting, further reducing medical registrar availability. Mornings saw exhausted night doctors trying to find post-take ward rounds (PTWR) to review their patients with, rather than the consultants finding them. Few work-based assessments were obtained, morale was low, and sleep was elusive due to unmet patient concerns.

Several workstreams were initiated:
1. medical registrars brainstormed a standardised handover process
2. negotiations started with the emergency department (ED) to allow bleep-free handover
3. Hospital at Night (H@N) programme was initiated
4. morning PTWR process was observed for several weeks to examine patterns of work and explore why night staff were not included
5. doctors on night shifts were asked about their experiences especially in regards to training opportunities and morale.

Evening handover now occurs in a standardised way. It is bleep-free following extensive work with ED to modify working patterns and timings. H@N is in an advanced stage of development and due to go live in June 2018. Morning PTWRs will now start in the operations centre, away from the acute medical unit (AMU), to allow executive oversight, easy co-location of night and day staff, and handover to the morning coordinating consultant. As ED commitments are now covered by the AMU registrar, the night registrar is able to attend.

Culture takes a considerable amount of time to change. The most important aspects of team working were embedded in the recent national Quality Criteria for General Internal Medicine and Acute Internal Medicine Registrars which I co-authored, ensuring a gold standard of behaviour.
Shuaib Quraishi

Organisation: Surrey and Sussex Healthcare NHS Trust  
Grade: ST6  
Specialty: Acute internal medicine and general internal medicine  
Mentor: Dr B Mearns

My role as chief registrar has been transforming. I have been embedded as an active member of the medical division at trust board level. Having mentors that include the deputy director of operations as well as the chief of medicine has allowed me to appreciate the wider role of leadership and management in improving patient outcomes. The training provided by the RCP has enabled me to develop and implement my leadership skills and undertake quality improvement. I have come to learn that collaborative working and engaging with various stakeholders are vital in initiating change.

Improving the diagnosis and management of urinary tract infections

Aim: To reduce the number of inappropriate antibiotic prescriptions, create awareness and educate doctors, and improve patient outcomes.

Urinary tract infection (UTI) is one of the most commonly diagnosed infections amongst hospitalised patients. Previous audit data show that we are inappropriately diagnosing and inappropriately prescribing antibiotics for UTIs, which can lead to side effects and harm to patients. Recent audit data suggest that 30% of patients treated for a UTI actually meet national guideline criteria. Urine samples were sent in 69% uncatheterised episodes where the clinical criteria for UTI were not fulfilled. There is over-reliance on urine dips for diagnosing UTI in the elderly, leading to inappropriate antibiotic prescriptions.

We identified there was a clear need for guidance, awareness and training.

Important stakeholders included microbiologists, the chief of medicine, IPCAS (infection prevention and control group), the lead pharmacist, infection control nurses, consultants, geriatricians and junior doctors. A focus group was held to explore process mapping and explore how we could achieve our aims. A questionnaire was used to explore doctors’ knowledge in the diagnosis and management of UTIs. The results of the questionnaire were analysed and another focus group was held to decide the next steps.

The questionnaire had 52 completed responses. We found that although doctors had good background knowledge on diagnostic criteria for managing UTIs, it was not put into practice. We also identified there was a clear need for guidance, awareness and training. 50% of people did not use any form of training to assist them in diagnosing and managing UTIs.

We plan to incorporate training into junior doctor induction and various educational meetings such as grand rounds and departmental meetings. Posters have been designed and will be placed in key areas (ED, wards, intranet, microguide app etc). Our geriatricians have developed podcasts which will be used as an educational resource. A longer-term vision is to develop a module composed of podcasts, videos and articles that form a blended learning approach. Following implementation, a re-audit is planned to measure if this has had an impact on inappropriate antibiotic prescriptions.
Clear national and trust guidelines are available regarding the management of patients receiving anticoagulation therapy. A lack of evidence for LMWH in renal impairment makes anti-factor Xa monitoring crucial in this population. Two separate significant bleeding incidents resulted in High-Level Incidents in which both management of high International Normalised Ratio (INR) and monitoring of anti-factor Xa levels were not compliant with trust guidelines. A rolling audit of the management of high INR (≥5) also demonstrated that compliance with trust guidelines dropped from 70% to <50% over a 12-month period.

I led a team of haematologists, pharmacists and nurses to design and implement two new anticoagulation prescription and monitoring charts:

- warfarin prescription chart for patients with kidney function ≥ 50%, which includes information to support prescribers in assessing and managing patients with raised INR
- therapeutic anticoagulation prescription chart for patients with renal impairment (eGFR ≤ 50ml/min/1.73m2) which includes an area for prescribing LMWH and monitoring of anti-factor Xa levels.

QI methodology was used to test the charts in one setting to assess its impact, building upon previous learning before implementation in other areas.

Targeted education sessions were carried out for various healthcare professionals to improve knowledge in monitoring and management of patients on therapeutic anticoagulation.

The new charts are being piloted with a re-audit of INR management and Xa level monitoring being undertaken to review the effectiveness of the intervention. Usage of various aspects of the chart such as choice of algorithm for warfarin loading and management of high INR are under review as part of the audit.

Initial feedback has suggested the chart is beneficial in supporting the medical team in selecting appropriate warfarin and LMWH doses and prompting when LMWH monitoring is needed. The plan is to roll the chart out across Manchester Royal Infirmary and use the audit data to guide future trust anticoagulation guidelines.
Dominic Reynish

**Organisation:** Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust  
**Grade:** ST6  
**Specialty:** Respiratory medicine and general internal medicine  
**Mentor:** Dr A O’Donnell

This reflects the early period of tenure as I started in post later than most of the cohort. Early on, I met with numerous key people, only to discover many others with valuable knowledge and experience. Face-to-face meetings were invaluable. By offering the post, the trust is self-selected as one that is engaged and interested in the role. I found that I was at least as keen to meet others as they were to meet me. The post has afforded me the unique means and opportunity to explore and do things that before only seemed like wishful thinking.

**Acute medical unit staffing mismatch**

**Aim:** To identify arrival times of patients by their referral source and compare medical staffing levels in order to best inform resource allocation and minimise delays in patient assessment.

At present, acute medical unit (AMU) waiting times are not subject to the same level of scrutiny as in the emergency department (ED) and AMU patients sometimes have to wait for prolonged periods. Patients referred by GPs may face the most prolonged waits, despite not having a prior inpatient assessment.

Data for AMU admissions in Royal Bournemouth Hospital for each hour were obtained for the period April 2014 to March 2018. These were subdivided by referral source (ED, GP or ‘other’) and by day. Referrals were then grouped into ED and non-ED. Days were grouped into weekdays (excluding bank holidays) and weekends (including bank holidays).

Time commitment to AMU clerking was calculated by the number of junior doctors rostered to AMU, multiplied by the hour expected to be seeing medical admissions, taking into account time split between two responsibilities, time allocated to handover, and commitment to other work (such as post-take ward round jobs). Results were consistent for both weekdays and weekends. For ED referrals the highest admission rate was between 4–5pm, non-ED was 5–6pm, both combined was 5–6pm.

The greatest number of rostered doctor hours was from 12pm on weekdays and 11am on weekends, until 4pm. Staffing levels fell over the evening and were lowest overnight.

Through this project I found that there is a staffing mismatch: peak admission rate occurs later than when staffing is optimal. This effect is most pronounced for non-ED admissions on weekdays.

Admission timings and rostering staff are both ‘wicked’ problems. Although medical rotas can be changed there may be other, more efficient solutions. These include altering the utility of ambulatory clinics, streamlining admissions by reducing information duplication, and utilising allied health professionals to aid with initial assessments. More work looking at delays in medical assessment may help instruct better resource allocation.
Ruwani Rupesinghe

Organisation: York Teaching Hospital NHS Foundation Trust  
Grade: ST5  
Specialty: Respiratory medicine and general internal medicine  
Mentors: Dr A Whiteside and Dr A Phillips

The chief registrar scheme has been life changing. My understanding of the complex systems necessary for delivery of frontline services has skyrocketed. I know firsthand how difficult leading and delivering change can be, and have gained insight into the challenges our colleagues in management encounter. Most importantly, I have been challenged to reflect on my own behaviours and the effect they have on the team. This introspection, together with the training delivered by the RCP – and seeing good leaders in action – has catapulted me on a journey to being a leader, not simply through title, but deed.

Safer care through better handover

Aim: To deliver high-quality handover between on-call teams by using a standardised system 100% of the time.

As chief registrar I was asked to improve medical handover. Five serious incidents and two critical incidents, in which poor handover was deemed a contributing factor, were identified over a 4-year period. The RCP Acute Care Toolkit 1 states that ‘improvement and standardisation of handover are vital keys to improvement in efficiency, patient safety, and patient experience’.

A baseline survey was sent to doctors, nurses and the critical care outreach team about their views on the quality and safety of handover, together with suggestions for improvement.

Many reported ‘variability’, ‘poor structure’, ‘lack of standardisation’ and lack of awareness that (ward) handover existed. Foundation year 1 doctors (FY1) in particular felt ‘uncertain’ about whether they were meant to be contributing or were ‘handing over information without knowing why’.

I tackled these issues by:

- introducing a checklist for the main handover meetings.
- improving education by delivering teaching to the current FY1 cohort and incorporating a session on handover into future FY1 inductions – I am also pursuing inclusion of handover processes into individual speciality junior doctor handbooks.
- trialling electronic handover.

Although evaluation is limited by the low response rate, snapshot surveys were carried out subsequent to the baseline survey, and found:

- 67% now report always knowing who is present, compared to 22% at baseline.
- staff report feeling ‘pleased with structured handover’, ‘significant improvement’ and more ‘confident …there will be time designated (for them)’.

Variability continues and the checklist is not always used. Anecdotally, this is linked to whether a consultant is present or leading handover. Following trials of electronic handover, we are waiting fixes to the IT system. In the interim, an adaptation of the RCP out-of-hours form is used.

The project began as a relatively simple task of improving handover, but expanded into a complex range of activities. It will take time for some of the actions to bear fruit. Engagement has been a challenge but there is evidence of improvement in handover processes.
Frequent on-call rota gaps had left trainees working with understaffed teams. Trainees raised concerns that they were not aware how to formally raise concerns regarding unsafe staffing levels, and were uncertain how to escalate concerns out of hours.

We investigated the organisation of the overnight medical teams and researched any existing protocols regarding raising staffing concerns. We also analysed data from the Hospital at Night system regarding rota gaps, and undertook a survey of junior doctors’ experience while on call.

Twenty junior doctors attended a forum regarding safety concerns associated with current staffing levels. We found that there was no formal protocol for trainees to follow when working understaffed shifts, and the actions taken by the trainees were very variable.

Of the 20 junior doctors surveyed, 95% had worked an on-call shift over the last three months with at least one doctor short; 60% felt stressed about working in understaffed rosters, and 70% felt that patient safety was at risk of being compromised due to staffing shortage.

Fortunately, 100% felt they would be able to phone the consultant on call regarding any concerns during the shift.

I relayed the trainees’ concerns to senior medical figures, highlighting areas requiring immediate attention. This included the development of an agreed protocol for trainees to follow out of hours when staff shortages may affect patient safety.

A ‘four step plan’ has been agreed for trainees to follow, which includes clear steps for informing the consultant on call and site manager, completing a ‘Datix’ or incident form, and recording and reflecting on the shift.

Trainees have been made aware of this four step plan through the junior doctors’ forum and email communications. Furthermore, posters highlighting this stepwise plan and how to fill in a Datix will be distributed.

A ‘four step plan’ has been agreed for trainees to follow, which includes clear steps.
In November 2017, an online survey was sent to 943 junior doctors working at UHL. We designed this survey to capture a comprehensive picture of junior doctor morale in several domains. Respondents used an ordinal scale of zero (lowest) to ten (highest) to rate: their overall morale, how valued and supported they felt at work, and how much autonomy they were given. Free-text qualitative comments were sought and responses were thematically analysed to identify common themes. Doctors also selected the top five factors that positively affected their morale, from a list of 20, compiled using published literature and local knowledge.

402 (42.6%) junior doctors responded, from a wide selection of departments, specialties, training and non-training grades. Doctors reported that they felt reasonably autonomous and supported, but less that their role is valued. From the free text comments ‘key themes’ were identified: team working and relationships, feedback, training and education, resources, wellbeing and pastoral support, staffing and workload, senior clinician support, and autonomy. The commonest factors that positively affected morale were ‘feeling part of a team’ (66.4%) and ‘being recognised for good practice’ (56.7%).

Our survey has provided insight into junior doctor morale at our trust. Qualitative data demonstrated a number of diverse themes and factors that influence morale, creating a dialogue between junior doctors, senior clinicians and managers. This dialogue has led to the development of a ‘Listening Into Action’ campaign. A diverse working group consisting of senior leadership and trainees is translating these results and ‘key themes’ into demonstrable actions to improve the working lives of junior doctors at UHL.

The survey created a dialogue between junior doctors, senior clinicians and managers that has led to the development of a ‘Listening Into Action’ campaign.
Approximately 15 patients each month die en route to Bart’s Heart Centre or within 12 hours of arrival. The centre has the largest number of sudden deaths in Bart’s Health NHS Trust, the largest NHS trust in the UK. The majority of these present as sudden cardiac arrests (whether or not attributable to a cardiac event), or cardiogenic shock. A bespoke service was required to meet the needs of bereaved families and to address the additional stresses experienced by front-line staff.

A multidisciplinary standard operating procedure was developed to address:

1. timely completion of coroners’ referrals and death summaries
2. emotional support for front-line staff
3. a bereavement clinic to provide a forum for families to meet with the clinical team
4. provision of written information suitable for a diverse multicultural population
5. improving the quality of death certification by junior doctors.

Input was invited from front-line staff, bereavement officers, end of life and palliative teams, religious leaders and the general public.

A survey of junior doctors was conducted to gauge their understanding of death certification processes and additional training was provided to address knowledge gaps.

Acknowledging the difficulty in measuring satisfaction of bereaved families, indirect outcomes included a reduction in formal complaints and serious incidents in relation to sudden deaths in the centre. Improvement in the turnaround time for discharge summaries for deceased patients and coroners’ referrals was measured by data collected on existing electronic systems. The quality of death certificates was measured by a reduction in queries raised by the Coroner’s Office, and indirectly by an improvement in test scores for juniors completing a knowledge based assessment after a teaching intervention.

Much of the focus on managing sudden death in hospital has been on expected deaths covered by existing national and local end of life protocols. Development of a service to address the needs of families and staff in the event of sudden death may be applicable to other PPCI centres in addition to emergency departments and other acute clinical settings.

Indirect outcomes included a reduction in formal complaints and serious incidents in relation to sudden deaths in the centre.
Shianne Varrier

Organisation: Royal Surrey County Hospital NHS Foundation Trust
Grade: ST6
Specialty: Rheumatology and general internal medicine
Mentor: Dr J Adams

My role as chief registrar has not been what I expected. It has, at times, been challenging, time-consuming, frustrating, but also eye opening, providing me with insight into the non-clinical aspect of medicine that I would never have gained otherwise. I feel privileged to have been given this opportunity to try to improve things within the (very) short space of time I have had! The role has helped me grow in confidence as a clinician, and in terms of management experience, and I wish I had longer than a year to do it.

Introducing a medical ambulatory care service

Aim: To set up a safe and direct in-hours medical service for patients not requiring an overnight admission to be promptly seen and discharged on the same day, thereby reducing zero-day admissions and streamlining access to acute medicine.

A two week pilot of the ambulatory care unit (ACU) service was run in December 2017 during working hours (8am–4pm). The service was provided by a medical registrar (SpR), overseen by an acute medicine consultant.

The ACU SpR triaged all GP referrals. Patients were booked in for admission to ACU on the day or later in the week and seen within 30 minutes of admission, then promptly reviewed by the acute medical physician on call within 2–3 hours of attendance. Management plans were made either requiring admission, discharge back to GP or further attendance post-investigation. The pilot found:

- approximately 25% of calls required phone advice to the referring GP and therefore potentially avoided attendance.
- approximately four patients were seen by within ACU on the day, with a conversion rate to admission of less than 25%. Most patients were either discharged directly or re-attended later in the week.

The number of calls from GPs to the acute medical SpR fell significantly during in-hours, allowing them to concentrate on other activities. Feedback demonstrated greater satisfaction with the management of the acute medical take.

The number of medical overnight admissions/prolonged length of stay over the day (8am–8pm) on-call shift dropped by approximately 15–20%.

Following the pilot, a permanent ACU service within the medical division was approved. The service is run by a dedicated junior doctor between 12–8pm, increasing junior doctors’ acute medical take numbers by 25% and allowing GP referrals to be diverted from the on-call team.

The ACU service has been given dedicated space within the hospital, which will allow ACU ‘hot clinic’ slots to be set up, overseen by acute medicine consultants to allow appropriate follow up of more complex patients. This will help to achieve trust compliance with the new Shape of Training Internal Medicine model for medical trainees from 2019.
We ran in-situ simulation programmes at two DGHs from 2015 to 2018. Simulations were run every two weeks and used local simulation materials with support from the trust simulation faculty. We developed a bank of scenarios: delirium, the deteriorating multi-morbid patient, falls, stroke, end-of-life care and communication scenarios around treatment escalation, nutrition and capacity. Sessions involved one trainee doctor and one nurse, and were facilitated by a simulation-trained senior elderly care registrar and nurse (practice development nurse or simulation lead). Sessions lasted 45 minutes including scenario and debrief. Latent errors were identified and acted upon via local established patient safety pathways.

100% of participants (including both doctors and nurses) found it useful to train with other members of the multidisciplinary team.

We conducted 42 sessions over two sites. Feedback was universally positive with 100% of participants (including both doctors and nurses) finding it useful to train with other members of the multidisciplinary team and valuable to train in their normal environment. A small number found it disruptive to their work.

Challenges included the difficulty of running a scenario due to lack of beds or staff at very busy times, dependence on registrar availability and ensuring sustainability when registrars leave the trust. To minimise these challenges, leadership and engagement from consultants and senior nurses ensured simulation was seen as a priority. We were creative, using other spaces to run scenarios when the ward was full. We also increased the number of faculty and started a simulation rota to promote the sustainability of the programme.

Running in-situ simulation on an ECU in a DGH is feasible and popular with staff. It improves interdisciplinary relationships, provides learning opportunities for juniors and teaching opportunities for senior trainees. We have developed strategies to deal with implementation challenges that will be useful for other elderly care departments looking to set up in-situ simulation.
We developed an ‘emergency geriatrics’ multidisciplinary team consisting of a consultant geriatrician, rapid response therapist, band 8 prescribing pharmacist and core medical trainee to work within ED. The consultant geriatrician also carried a ‘silver service’ telephone to provide access to specialist advice to GPs and community practitioners regarding admission avoidance and frailty syndromes.

The service’s activity and structure was developed using quality improvement methodology to improve productivity during the initial three months of operation. Service activity data was collected prospectively and validated by the trust’s patient administration system. 297 patients (85 ± 7.5 years, 67% female with a clinical frailty score of 5 ± 1.3) were assessed by the team during the first three months.

Of these, 152 (51%) were discharged to the community, 27 (9%) were transferred to an intermediate care facility and 118 (40%) were admitted to an acute hospital bed. Among the admitted patients, 39% were treated by geriatricians, 36% by other medical specialties and 25% in an outlying ward. 42% of the 118 patients subsequently admitted to the hospital had been assessed as having no acute medical need for admission. An average of 0.86 medications were stopped per patient.

There was limited use of the telephone service despite several community care providers feeling that it would help to reduce ED attendances. This was found to be due to limited community knowledge of the service.

The ‘front door geriatrics’ model is effective in delivering CGA to frail patients within the ED and reducing inappropriate admissions to hospital. However, a further benefit could be achieved through prolonged out-of-hours service cover. The positive results demonstrated the need for continuing the service, and as a result, a dedicated elderly medicine unit is currently under construction within our current ED.
UCLH employs a pathology e-requesting system to request blood tests. Clinical areas create ‘order sets’ of different blood test combinations in order to simplify and expedite pathology requesting. The trust’s Carter dashboard for pathology was reviewed to identify low clinical value, high cost tests across the trust. Once these were identified, the dashboard was interrogated further to identify the most frequently requesting clinicians or clinical areas.

Clinicians (and clinical leads) were presented with data to ascertain whether they would consider removing these tests from their order sets. Test ordering and overall expenditure was compared before and after the removal of individual tests. All tests could continue to be requested, but such actions required an active choice to do so by the requesting clinician.

Projected annual savings of ~£200,000.

One of the stroke team’s order sets included a full thrombophilia screen incurring costs of £14,828/month, despite the paucity of evidence that thrombophilia testing is clinically useful in acute stroke.

All tests for venous thrombophilia were removed, which resulted in a reduction in stroke team thrombophilia spend to ~£4477/month and represents an overall projected saving of ~£10,300/month or ~£125,000/year.

The emergency department (ED) requested ~20,000 clotting screens in the 2016/17 financial year, costing ~£215,000. The ED clinicians reviewed their practice and guidelines in response to this data and opted to remove the routine fibrinogen test from their order sets in March 2018, which is projected to save ~£70,000/year.

The cancer ambulatory care unit reviewed their requesting of routine group and saves and following a pilot project abandoned routine group and save requests, deferring to an on-demand process resulting in a projected annual saving of ~£20,000.

The use of Carter dashboards allowed rapid identification of low clinical value, high cost blood tests, prompting face-to-face conversations with clinicians and achieving projected savings of ~£200,000. In most cases, these tests were deemed to be of such limited clinical value that they were removed from order sets altogether.
The RCP chief registrar scheme
2017/18 yearbook

For further information
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