Foreword

I am delighted to introduce the yearbook for our 2020–21 RCP chief registrars. The RCP Chief Registrar Programme was established in 2016 as our flagship leadership programme and continues to grow year on year. The programme supports senior doctors in training to develop their skills and confidence in leadership, management and quality improvement. In turn, its success has now led to other programmes being created.

We recognise that this year has been challenging for our chief registrars, with the COVID-19 pandemic and having to deal with the unprecedented challenges faced locally and personally. On top of this, their quality improvement projects have taken a different focus from what might have been anticipated and they have had to adapt to the programme being delivered virtually for the whole year. However, our chief registrars have been able to make substantial improvements to processes, systems, experiences and rotas over the past year.

The yearbook highlights chief registrars and the projects and improvements they have made. It is clear they are all outstanding individuals, passionate and motivated to make change in their hospitals. They have made significant improvements to patient experience, services and staff morale, as well as developing their own skills and leadership qualities.

We wish our chief registrars every success for their future and hope that they stay involved in the RCP and continue to work with us throughout their careers.

Andrew Goddard
President, Royal College of Physicians
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Anant Gurung

Organisation: East Sussex Healthcare NHS Trust
Grade: ST7
Specialty: Acute internal medicine and general internal medicine
Mentors: Professor N Patel and Dr S Merritt

I spent my first few months as a chief registrar meeting senior members of the management team and understanding the pathways and NHS management structure. This provided me with a platform to engage with key stakeholders, junior doctors and consultants; we have collaborated in multiple projects to implement change and provide effective patient care. The training modules have provided me with a clearer understanding of QI methodology, the ability to recognise leadership and influencing styles and be able to inspire, implement and support other junior doctors in various projects. I feel virtual meetings have helped significantly in engaging my team during the pandemic. Overall, my year as a chief registrar has been invaluable and rewarding.

1. Introducing 10-minute acute medical unit (AMU) huddle
2. Improving and standardising the inpatient specialty referral pathway
3. Improving the flow of patients from A&E to medicine

Aims:
1. To assess the impact of a standardised morning meeting on patient flow, safety and team efficiency in the acute medical unit.
2. To reduce inpatient wait time for review by specialty teams.
3. To reduce patient wait time for clerking after being accepted for admission by the medical team.

10-minute AMU huddle
This allowed the nurse and doctor handover to highlight unwell patients, discharges and staffing issues, to prioritise ward rounds accordingly. We achieved higher early discharge rates, improved patient safety, better doctor–nurse communication and team coordination. Awarded winning poster at the Society of Acute Medicine conference.

Improving inpatient referral pathway
Poor referral pathway in the hospital contributed to delays in patient management decisions by specialty teams. This project made referrals electronic and paperless. Reaudit showed 91% of patients were seen in less than 24 hours, this also reduced junior doctors’ ward workload.

Streamlining patient flow, A&E to medicine
With increased pressure from COVID-19, this project aimed to identify and improve any factors that prolonged a patient’s journey from referral to clerking and senior review. A medical documents hub was created in A&E, an on-call medical laptop for take list access in A&E, and early consultant post-take to free junior doctors at peak times.

Other projects
> Developing e-prescribing (launch: September 2021):
  - Prescription templates for common medical conditions were introduced along with electrolyte disturbances to minimise delay and encourage safer prescribing.
> Setting up electronic dashboard in same day emergency care (SDEC):
  - This led to better team communication and patient flow.
> Improving on-call medical handover:
  - The handover room was relocated and handover times standardised – achieved higher attendance and defined roles of on-call team.
> Introducing Zebra devices and setting up hospital at night team:
  - All ward jobs would be generated as tasks and allocated through the device to the night on-call team along with auto alert of high early warning score (EWS) patients via Nervecentre (launch: August 2021).
Asanka Wijendra

Organisation: Royal Berkshire NHS Foundation Trust
Grade: ST6
Specialty: Trauma and orthopaedics
Mentors: Miss Claire Middleton and Dr Emma Vaux

My time as chief registrar has been equally enlightening and rewarding. The leadership programme provided me with a valuable framework with which to approach transformation in healthcare. Along with this, protected time dedicated to quality-improvement, educational and pastoral projects has given me the scope to make meaningful change. Overall, this year has provided me with invaluable experience for future leadership roles and a career as a consultant.

Fracture clinic: can we fix it?
Aim: To improve patient flow and efficiency of the Fracture Clinic Service.

The fracture clinic service at the Royal Berkshire Hospital often runs beyond its intended capacity, adversely impacting patient experience and trainee learning. With resources constrained and amid a pandemic, I chose to pursue a cost-neutral improvement strategy, invoking the principle of ‘marginal gains’. Process mapping and time-in-motion studies enabled us to identify bottlenecks and introduce interventions that have smoothed patient flow:

- Optimisation of radiology appointment times has helped avoid patients clustering at X-ray and subsequent backlogs in clinic.
- A redesigned check-in and check-out process has reduced the administrative burden on clinicians, enabling greater patient contact time.

An audit of the clinical workload informed a further set of changes:

- A new distal radius fracture protocol has ensured earlier involvement of sub-specialty surgeons where needed and has eliminated unnecessary follow-up.
- Initiation of a nurse-led clinic for the management of stable ankle fractures and postoperative reviews has enabled greater protocolisation of routine treatment and freed the capacity of specialist personnel for more complex cases.
- Introduction of a patient-initiated follow-up service has enabled patients to take a lead in their care with an elimination of appointments that provide little clinical value.

Further quality improvement projects:

- Working in collaboration with the emergency medicine and radiology departments we developed a protocol that will improve access to out-of-hours MRI scanning services for patients with suspected cauda equina syndrome. The project hopes to increase clinical efficiency, reduce admissions and improve patient experience through the more efficient use of existing radiological resources.
- As part of a trust working group, we commissioned and piloted a mobile image capture solution. This has enabled clinicians to capture secure medical photographs at the bedside with seamless upload to the electronic patient record. We hope to progress to a wider trust rollout in the near future.

Educational, research and pastoral activities:

- Initiated and coordinated a consultant-led webinar programme, ensuring trainees continued to receive teaching opportunities during the pandemic. Delivered a series of simulation sessions for trainees and mock ST3 interviews for those applying to higher specialty training.
- Acted as associate PI for the CRAFFT trial, with our site currently 4th highest for recruitment nationwide.
- During the peak of the pandemic, my fellow chief registrars (Jessica Palmer, Sneha Singh and Hannah Sellars) and I provided weekly decompression sessions and pastoral support for redeployed doctors.

With these projects now established I hope to evaluate their impact over the coming year.
Our chief registrar year allowed us to contribute to multiple projects as team members and take the lead on several others.

We were able to champion initiatives started by the trust’s previous chief registrars, including the multidisciplinary team (MDT) night safety ‘huddle’ within the emergency department (ED) and maintaining and creating new interspecialty link roles.

The main work we would like to present here includes:

- **Junior doctor virtual calls linking senior leaders and wider workforce (AD/RS)**
  - Trust-wide with the trust’s medical chief registrars, as well as ED specific meetings.
  - The calls facilitated real-time bi-directional communication in times of rapid organisational change.

- **Critical incident investigations and complaint responses (AD/RS)**
  - Leading these projects in a supported way has been excellent preparation for consultancy.

- **Junior doctor ED rota (RS)**
  - Workforce planning and management, as well as trainee representation and wellbeing championing.

- **‘Pit-stop’ project (RS)**
  - Introducing rapid assessment and triage for patients arriving via ambulance to GRH ED.
  - Improved time to senior decision maker and appropriate streaming to specialty same day emergency care areas.

- **Emergency medicine teaching programme (AD)**
  - Ensuring registrar teaching could continue at a high standard throughout the pandemic using virtual platforms.

- **In-situ, multispecialty paediatric resuscitation simulation in the ED (AD)**
  - This project supported ED MDT education and engagement, interspecialty team working and prevented skills fade while paediatric patients were mainly being streamed to the paediatric assessment unit.
  - It proved that such an endeavour was feasible in a busy district general hospital ED.
Bethan Davies

Organisation: University Hospitals Sussex NHS Foundation Trust
Grade: ST6
Specialty: Geriatric and stroke medicine
Mentor: Professor Mahmood Bhutta

Over the course of the year I developed a much better understanding of my own leadership style and where my strengths lie, which has been really empowering. The programme gave me a greater appreciation of the roles of colleagues in other parts of the organisation who have been great allies in generating momentum for change – it has been a privilege to work with people who I would never normally come into contact with and I have learnt so much from them.

Developing sustainable healthcare in an acute trust

Aim: To establish the clinical workstream of the trust’s sustainability steering group and to develop projects addressing the environmental impact of healthcare delivery.

Medical equipment, pharmaceuticals, anaesthetic gases and metered dose inhalers make up a significant portion of the carbon footprint of an acute NHS trust. The purpose of establishing a clinical workstream of the trust’s sustainability steering group was to enable clinicians to be at the forefront of initiatives to reduce the environmental impact of the care we deliver.

Terms of reference were agreed with senior management and we have held regular meetings open to all clinical staff to share ideas and experience. Lack of dedicated clinician time to carry out this type of work was a major barrier and one of our most significant achievements has been to secure funded time for a clinician to lead the workstream. During the year, ‘environmental strategy’ was identified as a new strategic initiative for our trust and the clinical workstream has been incorporated into the governance structure for this.

I have also supported the ‘green ambassadors’ programme at the trust, running workshops with our energy and sustainability and QI managers to help staff develop sustainability projects in their own departments and feed into the clinical workstream.

This year has been incredibly rewarding – I have been given the freedom to develop projects that I am passionate about and one of the most enjoyable aspects has been the very collaborative and non-hierarchical nature of the work, cutting across many of the traditional divisions between departments and staff groups. My confidence has grown enormously and I have learnt how to adapt my leadership style for different situations.
Charlotte Parr

Organisation: Nottingham University Hospitals NHS Trust
Grade: ST6
Specialty: Acute medicine with a special interest in dermatology
Mentor: Dr Simon Roe

I was offered the appointment of chief registrar in March 2020, just prior to the first lockdown. Although I wasn’t due to come into post until August, I immediately got involved and worked closely with the outgoing chief registrar to execute and communicate workforce changes that were required in response to the pandemic. While COVID-19 has been a significant factor at play in most of my projects, it has also served as a catalyst for change and a clear driver for reducing length of stay through criteria-led discharge (CLD) and same day emergency care (SDEC) models; urgent and robust assessment of sick patients by the acute rescue team (ART) using the deteriorating patient proforma (DPP) to support robust documentation, in particular around escalation and resuscitation decisions; and the importance of effective bi-directional communication and support for junior doctors.

1. Introduction of an acute rescue team (ART)
2. Development of deteriorating patient proforma
3. Criteria-led discharge (CLD)
4. Quality, risk and safety specialty registrar leads

Aims:
1. To reduce the response time and provide early senior input to deteriorating patients.
2. To consistently improve the recording of deterioration episodes.
3. To use CLD as a safe pathway for discharge to enhance patient flow and reduce length of stay.
4. To provide a structured opportunity for senior registrars to experientially learn about governance.

The acute rescue team (ART) and the deteriorating patient proforma (DPP)
The ART was launched in August 2020 in response to increased failure to rescue incidents occurring out of hours. Insufficient middle-grade cover resulted in poor compliance with Royal College of Physicians NEWS2 guidance and posed a risk to patient safety. Five middle grade doctors were appointed to a unique stand-alone rota to provide urgent response to deteriorating patients, working closely with junior doctors and Hospital24 coordinators. Feedback and outcome data is positive; substantive funding for continuation of the programme from August 2021 has been secured.

As part of this, we developed a deteriorating patient proforma to standardise and optimise the documentation relating to a deterioration episode. The DPP resulted in improvement in both the graded quality of documentation (National Confidential Enquiry into Patient Outcome and Death (NCEPOD) approach) and structured judgement case review (SJCR) rated quality of care for a deterioration episode; it is now widely used across the trust and has been shared on the National Deterioration Forum.

Criteria-led discharge
Criteria-led discharge aims to facilitate the discharge of patients identified by senior doctors as appropriate for discharge by a junior doctor or member of the MDT once specific identified clinical criteria are achieved, with the aim of improving discharges earlier in the day and at weekends. This was introduced across medical and surgical wards within the division and has been widely adopted in both settings, there has been interest from other divisions for it to become part of the trust’s discharge toolkit.

Quality, risk and safety specialty registrar leads
Development of pioneering roles for senior registrars to work alongside their specialty governance leads to experientially learn more about quality, risk, safety and effectiveness, alongside their clinical role, in preparation for consultant posts has been positively received. A programme of activities relating to each domain has been created, we hope this not only addresses the registrar curriculum needs, but demystifies governance processes and encourages engagement with patient safety.
Chinwe D.B. Braide-Azikiwe

Organisation: Darent Valley Hospital, Dartford and Gravesham NHS Trust
Grade: ST5
Specialty: Renal medicine
Mentors: Stephen Fenlon and Jonathan Kwan

I had some previous leadership experience with no formal context to it prior to joining the programme. The programme provided structure and context to my leadership experience opportunity. The training was very helpful in evaluating stages of projects, adjusting strategy and responding to local circumstances and dynamics.

1. Organisational changes during a pandemic: structural, behavioural changes and resilience in the second wave.
2. Junior doctor contract breach: rota design, rota compliance and implementation.
3. EPMA implementation team
4. Wellbeing: junior doctors’ mess
5. RSM presentation

Aims:
1. Tracking adaptations and changes within the organisation in response to the second wave of the pandemic.
2. Dealing with the sequelae to a trust breach incident, managing the consequences and preventing recurrence.
3. Clinical input to trust’s electronic prescribing and medicines administration (EPMA) implementation plan.
4. Doctors’ mess refurbishment and update.
5. RSM presentation to trainees.

Tracking the changes that the organisation underwent in preparation for and response to the second wave of the COVID-19 pandemic: working patterns, team dynamics, doctors’ rotas, leadership roles in the fast-paced and evolving situation of the pandemic. Reflecting on the aftermath and consequent changes.

I encountered a situation where there had been a significant breach in the junior doctor contract and had the experience of navigating that situation from a management perspective: identifying and addressing the cause of breach, attempting to mitigate consequent impact on working lives and preventing future occurrence.

Engaging with EPMA project working group, I provided a doctor’s perspective and input into the development and implementation of the project. This is an ongoing project within the trust because of the potential benefits of electronic vs paper prescribing; this is a good example of an existing project within the trust that could create a wider impact.

Liaising with estates and facilities, with input from the wellbeing team, to refurbish existing doctors’ mess. An example here of a project that was planned but paused by events of the pandemic. I worked with a medical director in this situation to navigate reactivating plans and adjusting expectations within a short time frame.

Working with a fellow chief registrar to present to the Royal Society of Medicine’s acute medical trainees training series was a lovely opportunity to promote the RCP Chief Registrar Programme to current and future trainees considering their future leadership training paths.
Courteney Mathewson

Organisation: North Bristol NHS Trust
Grade: ST5
Specialty: Acute medicine
Mentor: Dr Kiaran Flanagan

I have always had an interest in what is happening behind the scenes but not known how to get involved and struggled to create meaningful change in QI work. The Chief Registrar Programme was ideal in helping me overcome this.

I started in a new hospital after maternity leave, but found the role immediately opened so many doors. I now appreciate what is happening behind the scenes and the networks of people responsible for making a hospital survive and thrive during such uncertain times. Teaching and support from the RCP was invaluable in strengthening and focusing my projects as well as considering my personal approach and strengths as a leader.

Most importantly for me, the discussion and support the chief registrars have given each other this year has been essential in trying to learn and navigate the challenges of becoming a clinical leader during a pandemic.

1. Launching next big thing – a new innovation award
2. Improving medical training – supporting the transition to IMT3

A year into the pandemic my trust had seen dramatic change and fatigue among staff. Along with another chief registrar, I designed an innovation award to encourage creative thinking; this supported the best ideas and existing projects to achieve success and sustainability.

We secured executive support and £50,000 from the hospital charity. The competition was a huge success with over 50 applications and diverse ideas, from staff wellbeing projects to groundbreaking patient initiatives. The quality of the finalists led the charity to increase their funding to £130,000. The trust is excited for this to be an annual event, enabling staff on the ground to deliver meaningful change for their patients and colleagues.

I was also very committed to making improvements for internal medicine trainees (IMTs). IMT is still in its infancy and 2021 will see the first cohort of IMT3s. After working with trainees it became clear that some problems from the old curriculum still existed and had been exacerbated by the pandemic, these included issues around getting outpatient experience and anxiety about becoming the medical registrar.

I designed interventions to support trainees to step up to the registrar role, including ‘supporting acting up’ shifts and a regional simulation course aiming to develop and discuss the ‘grey-skills’ of a registrar. The feedback from both was excellent with the majority of our IMT2s subsequently feeling confident enough to support gaps in the registrar rota. I worked with senior hospital leaders in medicine and education to improve access to clinic, including developing a month clinic block with palliative care experience to start from August.
Dalia Mudawi

Organisation: Wythenshawe Hospital
Grade: ST6
Specialty: Respiratory
Mentor: Dr Sally Briggs

The Chief Registrar Programme has given me a great insight into hospital management and leadership strategies. I have been fortunate to work with senior management staff who are committed to improving patient care and junior doctor experience. The programme has equipped me with the knowledge required to execute a number of quality improvement projects and engage key stakeholders in my work.

Improving junior doctor experience

Aim: To improve junior doctor morale and satisfaction with medical handover, communication and accessibility to clinical guidelines through a series of linked quality improvement projects.

1. Formalising medical handover
   The medical handover has previously been criticised in the General Medical Council (GMC) survey and Health Education England – North West (HEENW) visit. This project aimed to improve junior doctors’ satisfaction with handover by making it more timely, educational, and to ensure adequate documentation for medio-legal purposes. A seating plan, learning board and online handover checklist were introduced. The changes led to a 38% increase in the number of doctors rating the handover as good or excellent, 87% increase in documentation of sick patients and a 33% reduction in mean length of handover.

2. Improving accessibility to clinical guidelines: uploading onto smartphone app
   An initial app pilot found that 94% of users agreed or strongly agreed that guidelines were easily accessible via the app compared with only 14% on the intranet. The median access time on the app was 30–60 seconds rather than >5 minutes in the intranet, and over a 30-day period, guidelines were accessed on the app >200 times. The app developers are now in discussion with hospital governance regarding further development.

3. Junior doctors briefing (JDB)
   This project was continued from my chief registrar predecessor and aimed to improve communication during the pandemic. A JDB document detailing forthcoming staffing gaps, teaching links and key clinical updates is disseminated on a weekly basis. This contributed to >70% increase in junior doctors reporting satisfaction with the level of communication received from management. Nominations for monthly above and beyond recognition awards were published on the JDB, which also helped lift morale among staff.
Our team has enabled eRostering to be implemented for all doctors in the trust in phases, with some using the system for leave management and others using a fully functioning e-Roster with app-based viewing of shifts, self-rostering, activity management and high-level overview of shift vacancies. Leave requests can be made via an app in a matter of seconds and approved by rota coordinators at the touch of a button, improving on the previous system of paper forms requiring multiple signatures. The system also ensures that none of the rest requirements in the junior doctor contract can be breached, ensuring improved wellbeing.

The medical establishment report used a range of data sources to assess the medical staffing numbers in each area of the trust. General Medical Council (GMC) national training survey data was used to identify areas reported as having a high workload for both trainees and trainers. RCP guidance on staffing levels where available was used to establish the recommended baseline staffing and compare with the present staffing levels. Benchmarking against other similar trusts was undertaken using the NHS Model Hospital platform to identify the trust’s position in terms of staffing numbers and costs. Internal HR and finance data was used to identify areas where further staffing investment was desirable. This report was the first of its kind and identified key areas in the trust requiring amendments to medical staffing levels, and fed into long term plans for addressing these.
Dominic Cottrell

Organisation: South London and Maudsley NHS Foundation Trust
Grade: ST5
Specialty: Psychiatry
Mentor: Michael Holland

Chief registrar teaching has been invaluable for developing the practical tools for making changes. The time available to work on my projects has been vital to bring them from conception to completion.

SpR/consultant mentoring scheme

Aim: To improve the readiness of specialist registrars (SpRs) to take up consultant roles.

I recruited a cohort of consultants who are within 5 years of being awarded a certificate of completion of training (CCT) and paired them (based on shared clinical interests) with an SpR within a year of CCT. The costs were minimal, but there was a significant impact in terms of boosting confidence, understanding the role of the consultant and increasing likelihood of applying for a consultant role. The next step is to expand the programme and offer training for the mentors to boost recruitment.
Georgina Barrows

Organisation: Nottingham University Hospitals NHS Trust
Grade: ST6 (OOPE)
Specialty: Acute internal medicine
Mentor: Mark Simmonds

Taking on this role mid-pandemic has been a hugely valuable experience. In addition, having dedicated time to attend relevant, specific training and access resources, discussions and facilitated sessions has allowed real-time translation of leadership theory into practice. Built into the programme has been the ability to discuss projects, ideas, troubleshoot challenges and initiate collaborative working with peers, which has underpinned my achievement as chief registrar this year.

Working for wellbeing (A principle rather than a project)

Aim: Maximising junior doctor experience through a variety of aspects; pastoral, educational and environmental.

Wellbeing has many facets; my activity this year has had multiple strands.

Firstly, enabling formal positive feedback for staff, by setting up a GREATix reporting system, which will outlast the current pandemic pressures we are all experiencing and celebrate ongoing success.

Secondly, establishing networks between chief registrars, the junior doctor forum (JDF) representatives, PMED and associate college tutors as advocates for junior doctor colleagues. Specifically, focusing the work of those networks to promote and uphold standards for junior doctors, including the regional Health Education England Midlands’ charter and staff safety.

Thirdly, significant operational and strategic work:

- initiating a junior doctor social media communication network; staff found it hard to keep up with educational opportunities and important updates communicated within the trust from both managers and post-graduate education – particularly used during COVID-19 waves, but still ongoing

- establishing formal ‘Hospital24’ handover and mid-shift ‘sit-rep’ on both campuses in the trust; streamlined on-call teamworking, facilitating a nimbler and more responsive workforce, and visibility of senior staff (particularly out of hours), resulting in enhanced patient safety and staff satisfaction

- consulting in workforce responses to COVID-19 pandemic staffing, particularly when winter pressures were also high, with an eye on ensuring pastoral care were also a priority

- deliberate revision of the registrar working patterns and roles in response to the COVID-19 pandemic, and again for the year ahead in light of shape of training and its ensuing changes.

Developing a ‘registrar ready’ course to be delivered early in the IMT3 year to aid the transition for this next generation of medical registrars.
By completing the chief registrar leadership training I have been able to gain confidence in approaching and talking to senior leaders within my trust about my ideas. This was key in developing the ‘Next big thing’ competition which involved our trust’s QI and perform team, charitable donations and trust board approval.

**Next big thing: an innovation competition**

**Aim:** To engage all staff groups in innovation within North Bristol NHS Trust.

My primary project, in collaboration with our other chief registrar, was ‘Next big thing’ – an innovation competition. Winners received a support package to enable their ideas to come to life, including coaching from a senior leader and QI team and funding of up to £50,000 from the trust’s charity. It successfully ran this year with over 50 applications and now forms part of the trust’s regeneration post-COVID strategy. It enables all staff to be better engaged with improving the quality of patient care and their own environment. It was accepted for a poster presentation.

I have also completed a number of other laboratory projects examining the utility of various testing methods in improving patient outcomes:

1. Rapid antimicrobial susceptibility testing (RAST) and the impact on clinical outcomes: resulting in a hold on its introduction at NBT as it was not felt to have sufficient impact. Accepted for a poster presentation.

2. Introduction of the CSF Biofire platform and its impact on patient care: this project demonstrated a significant potential impact on antimicrobial stewardship. This platform has now been adopted by the laboratory.

3. The utility of introduction of 16SPCR to Severn infection sciences: resulting in better antimicrobial stewardship and diagnostics in bone and joint infection. This was accepted as a poster presentation. A project is now underway to develop an in-house testing method at NBT.

During my Chief Registrar Programme I was offered a consultant post at Royal United Hospital where I have put the skills learnt into practice.
Gulrays Jamie

Organisation: Frimley Health NHS Foundation Trust – Wexham Park Hospital
Grade: ST4/5 (OOP)
Specialty: Cardiology and general internal medicine
Mentors: Dr Gareth Roberts, Dr Andrew Cox and Dr Harish Patel

The RCP leadership development programme was the highlight of the year. It was excellently run by Tom, Edith and Beth and gave a theoretical framework on which to tackle the challenges I faced. It also gave us the opportunity to interact (virtually) with our fellow chief registrars. The leadership training programme gave the feeling of a tangible, integrated programme – which was particularly important as we were not meeting in person at the RCP.

Syncope pathway

Aim: To reinvigorate and streamline the syncope pathway.

Syncope service
I created, de novo, a new ED pathway which is going live currently – with the GP pathway to follow. There is now a clear pathway of which patients to discharge / refer to syncope clinic / keep in hospital. To complete this project I had to interact with the medical service manager, various consultants, nurse specialists and chiefs of service. I also had to ensure I was up to date with all the various international guidelines and evidence.

COVID-19 emergency rota
A large section of my time – 3 months – was spent creating and managing a rota for 104 junior doctors to cover every ward in the hospital. This was a mammoth task and I have a massive amount of respect for anyone dealing with rota issues! It required close liaison with the college tutor, deputy medical director and chiefs of service. It might sound strange, but this was the most demanding undertaking I’ve ever had in medicine – there were no real ‘off days’ and certainly no annual leave, but to keep the hospital safely staffed was rewarding.

Education
I have been able to use the dedicated time given to take part in running simulation programmes for trainees and giving teaching sessions.

Overall
The programme was great for unlocking new opportunities and exposure to the senior leadership team. If you think you would benefit from protected time for quality improvement and management, or simply want to see if this side of medicine interests you, I highly recommend applying!
As a chief registrar in respiratory medicine during the pandemic, I had ample opportunity to develop my clinical and leadership skills, while representing and acting on behalf of all the junior doctors and the respiratory department.

The skills learned over the year have shaped me into a compassionate flagship leader with a positive attitude, endless dedication and tireless energy allowing me to develop and implement several quality initiatives together with the medical directorate team, including the medical divisional staffing reconfiguration and improving the overall wellbeing of the trust’s workforce, while ensuring the best quality patient care could be delivered throughout the pandemic.

While working in a leadership capacity, I also upheld enhanced clinical responsibilities: I looked after severely unwell COVID-19 patients on the respiratory high dependency unit and played a crucial role in their follow-up in the multidisciplinary outpatient clinics.

I became the associate principal investigator for the RECOVERY trial; a sub-investigator in COVID-19 vaccine research projects, including the EMSEMBLE and COMFLU trials, and represented the accomplishments of the trust on several national and international platforms, including the British Thoracic Society, the Royal College of Physicians and the International Forum on Quality and Safety in Healthcare. The trust commended my leadership skills and exemplary performance in addressing local challenges and priorities around service improvement, education and training, engagement, morale, workforce and sustainability, and bestowed me with the GEM award (Going the extra mile) for my contribution.

The skills and knowledge gained with this experience will be invaluable for a successful career, especially when taking on future leadership roles.
Jalpa Kotecha

Organisation: Epsom and St Helier University Hospitals NHS Trust
Grade: ST5
Specialty: Rheumatology
Mentor: Dr Simon Winn

Through the chief registrar modules, I was able to develop a thorough understanding of quality improvement methodology, which helped me with various projects throughout my year as chief registrar. In particular, I learnt valuable lessons about successfully leading from the middle and how to identify and engage key stakeholders most likely to help take a project forward, this helped me to eliminate many of the frustrations I would otherwise have met in trying to achieve my goals. The team at the RCP were supportive and encouraging throughout and we had some truly productive discussions, despite the sessions being delivered entirely on a virtual platform due to the COVID-19 pandemic. Overall, the year has been a very rewarding one – despite the challenges posed by a second wave of the COVID-19 pandemic. Along the way I have enjoyed becoming part of the chief registrar network.

Improving the patient journey through hospital

Aim: To improve the patient journey through hospital by ensuring coordinated care through standardised board rounds, improved communication within the multidisciplinary team (MDT) and efforts to minimise delays to discharge.

At the beginning of my chief registrar year, there were significant discrepancies between board rounds on different medical wards. Board rounds are a vital component of modern ward rounds (RCP 2021). Along with members of the service improvement team, I worked to standardise the board round process. First, we provided guidance on the timing of board rounds, team members who should be present and what should be discussed, via prompt cards. This was reinforced with ward managers, therapy teams and junior doctors.

Following this, we introduced the ‘criteria to reside’ (CTR) system of selecting which of 11 criteria accounted for a patient requiring ongoing inpatient care. Analysis of this led to the realisation that IV antibiotics was the commonest selection, prompting me to undertake a quality improvement project to encourage antimicrobial stewardship. This involved educating junior doctors on aspects to consider when contemplating an IV to oral antibiotic switch, and optimising use of an electronic report identifying patients on IV antibiotics for >72 hours.

Alongside implementation of the CTR system, we encouraged use of the online patient tracker system to document the CTR and further streamline the process.

Following our work, board rounds were taking place regularly with a standardised structure, with the patient tracker being used on most medical wards.

Other work included updating the directory of services for the St Helier site, which had been created by a previous chief registrar, in order to improve communication between teams and in turn the patient journey through hospital.
Jennifer Callaghan

Organisation: Great Western Hospital NHS Foundation Trust
Grade: ST5
Specialty: Geriatric medicine
Mentor: Carolyn Mackinlay

The chief registrar leadership training was a good foundation for setting up and leading a quality improvement project. It also gave me a useful insight into my own leadership style, as well as the styles of others, and how to use this to overcome barriers I may encounter.

Improving weekend and weekday medical ward handover

Aim: To improve safety and efficiency around medical ward handover, both at the weekends and on weekdays.

My first step in improving handover was to improve weekend handover. The previous handover system – each ward populating a handwritten piece of paper placed in a folder – was considered to be dangerous and had led to multiple incidents, including where handovers had been missed, often leading to delayed and suboptimal care for patients. Using a programme the trust was already utilising – which kept costs neutral – I implemented an electronic handover system. This system is more time efficient (increased efficiency by 25% on surveys), user friendly (25% increase) and safer (48% increase).

After this ‘early win’ I led a team to create a fully electronic daily handover for the ward – replacing the well-established ‘ward lists’. These are populated by junior doctors on each ward each day by hand. Surveys and exception reports revealed that juniors were starting work 15–30 minutes early to create the lists. The handover I created is fully electronic and automatically updates when new patients come onto the ward or move bed space. The information contained within the handover is also shared and accessible on handovers done by nursing colleagues, therapists and discharge teams. Therefore, all MDT members have the most up-to-date handover at all times. This has eliminated the need for a junior doctor to attend the ward early each day, saving an estimated 3 hours per day in junior doctor time across the trust.

I have thoroughly enjoyed undertaking this project – working with a wide range of doctors within the hospital as well as other departments including IT, QI and senior divisional leadership.
Jessica Palmer

Organisation: Royal Berkshire NHS Foundation Trust (RBH)
Grade: ST6
Specialty: Geriatrics
Mentor: Dr Antoni Chan

Across the five modules provided by the RCP team I have learnt a huge amount about myself and my strengths and weaknesses, and crucially how to work with my traits to be a more effective leader. The QI theory work has taken me far beyond the simplistic plan, do, study, act (PDSA) cycles of past attempts at QI and made my projects this year far more robust and sustainable. The opportunity to work with my brilliant chief registrar colleagues across the country on action learning sets was inspiring and has given me an amazing network for my future career.

RACOP

Aim: Developing and improving the rapid access clinic for the older person (RACOP), by increasing referrals and improving MDT staffing.

My main focus this year was on developing the RACOP service at RBH and trying to strengthen its ability to provide an admission alternative for the local frail elderly population. I developed an entry for the service to be included in a database for local GPs, and a similar database for 111 referrals. This included a decision tree and a referral proforma to improve the quality of referrals received by the service. We also worked with the local ambulance service and now have an agreement that their clinical staff can make a direct referral to the clinic as an alternative to admission to hospital for appropriate patients. I have also been able to secure an agreement to create posts for a dedicated nurse and OT for RACOP, which will allow for a more complete comprehensive geriatric assessment (CGA) – recruitment for these posts will commence soon.

I also picked up a project I had been part of when previously working at the trust, regarding discharge summaries for patients who die in hospital. We are about to launch a new electronic template for these letters to improve communications with our GP colleagues.

I was also involved in a range of committees including the JDF, Medical Education committee, Electronic Patient Record Design committee and the patient safety forum. Through these I was able to advocate for medical juniors on a wide range of issues, from induction to electronic prescribing difficulties. I had the huge benefit of working with chief registrar colleagues in the emergency department, trauma and orthopaedic and general surgery, allowing us to work on cross specialty issues and support juniors through the difficulties of redeployment and escalated rotas.
Joe Hetherington

Organisation: Croydon Health Services
Grade: ST5
Specialty: Geriatric and general internal medicine
Mentors: Dr Karen Kee and Dr Reza Motazed

Taking on the post of chief registrar at a trust I had already worked at provided me with a unique perspective. The role has allowed me to explore and address local issues and pressures I was already aware of. Alongside experience in QI, I have also developed my skills in leading, managing and influencing change. The training modules delivered by the RCP have equipped me with not only an improved understanding of quality improvement and change management, but also a better understanding of workplace cultures, of others and of myself.

Hospital at night: analysis and improvement of overnight working practices at Croydon University Hospital

Aim: Redesign the existing ‘Hospital at night’ model to improve attendance from different teams, improve communication between teams and improve patient safety out of hours.

Hospital at night

The existing ‘Hospital at night’ system was not functioning as intended. Stakeholders were engaged, and the existing ‘Hospital at night’ meeting was redesigned and relaunched, aiming to facilitate better communication between teams and collaborative working overnight. Engaging and obtaining feedback from participants has been essential to this process. Analysis of data has shown clear improvements, although there is still work to be done. The results are being fed back and used to inform ongoing cycles of improvement work.

Collaborative working

Despite the limitations imposed by the pandemic, working alongside fellow chief registrars has been a fantastic experience. As well as sharing ideas, learning and experiences, we have been able to collaborate remotely on projects.

Other projects

These have included skills lab training for medical trainees, improving documentation of clinical frailty scores, improving recruitment to clinical trials locally and providing input into new IMT3 rotas.

Maintaining the link

The chief registrar role often positioned me as a conduit between junior colleagues and senior clinicians/managers. This was particularly important as we navigated the second wave of the COVID-19 pandemic, but also in facilitating medical registrar forums to address local issues, and being able to advocate on behalf of junior colleagues in discussions with senior management.

‘You are the project’

As well as undertaking various projects at the trust, this year has also given me space to learn and develop as a future leader. What I have learned about QI, change management and leadership, and the skills I have developed, will stay with me throughout my career.
Throughout our RCP chief registrar year we took an active role in medical staffing, recruitment of trust doctors, COVID-19 redeployment and management of day-to-day staffing levels throughout the medical directorate. We embedded a new process of daily handover ensuring key points were covered in a shorter and more efficient process. We established a ‘week ahead’ process to view staffing, assess gaps, sickness and locum need.

This work was part of a business case for medical rota support and a separate business case to reassess junior doctor locum rates to bring our trust in line with the rest of our region. Although this increased locum spending, there was a significant reduction in locum gaps to ensure safe staffing levels. To balance this out we also performed a trust-wide infection prevention and control audit of personal protective equipment, and a programme of staff education and intervention which rapidly reduced staff sickness and cost savings to the trust, this was subsequently presented at a national conference.

During our time as chief registrars our trust was awarded funding to improve our same day emergency care provision, we were involved in trialling a changing of processes to directly admit GP patients bypassing the emergency department, building works were completed and we then supported successfully embedding our new medical model for admission to medicine.

The RCP chief registrar training helped us to have the broader understanding of how we could support our trust through a process of rapid and continual change. Understanding our own leadership style, team dynamics and personality types gave us the skill base to support and sustain effective changes where we were needed within the trust.

COVID-19 pan hospital rota team

Throughout our RCP chief registrar year we took an active role in medical staffing, recruitment of trust doctors, COVID-19 redeployment and management of day-to-day staffing levels throughout the medical directorate. We embedded a new process of daily handover ensuring key points were covered in a shorter and more efficient process. We established a ‘week ahead’ process to view staffing, assess gaps, sickness and locum need.

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Julia Scaife

**Organisation:** Swansea Bay University Health Board  
**Grade:** ST5  
**Specialty:** Geriatric and general internal medicine  
**Mentor:** Dr Manju Krishnan

The external support through this programme has been invaluable. To receive high quality training by enthusiastic, skilled, non-judgemental experts has definitely championed us in this difficult clinical and managerial year. The peer interaction is refreshing and can add insight and depth to improvement project ideas and solutions. I’ve discovered more about myself and certainly grown in my understanding of how I can lead well now and in the future.

**Try again: making changes to the acute medical take**

**Aims:**

1. **To increase the efficiency, timeliness and function of the ‘medical take’ list so it integrates with the ward list through use of ED SIGNAL.**
2. **For the new system to be in place before doctor changeover and a new medical SpR rota in April 2021.**

1. **Introducing an integrated electronic list for the medical take.**
   
   My main project was transitioning the medical take list from a ‘word document’ on one computer to an integrated platform that is visible throughout the hospital and forms the ‘ward lists’ as the patient moves from the ED. This had been tried many times before and this time succeeded.

2. **Doctors’ forum and communication**
   
   A new doctors’ forum has been created to cover topics such as education, training, organisational communication and wellbeing, with clinical and management representatives present.
   
   Sharing information is difficult to do but it signifies trust in the recipient and can empower the workforce and increase engagement. The chief registrar role places you in receipt of lots of information and I’ve enjoyed navigating when and how to disseminate such information.

3. **Rotas and rest space**
   
   COVID-19 gave me the joy of reworking many rotas and championing for extra rest spaces to try to mitigate overcrowding in ‘the mess’.

4. **QI Awards**
   
   Improvement endeavours are happening all around us, they are integrated in curriculums and are relevant and important for all of the multidisciplinary team (MDT). I had the pleasure of pushing for a health board wide QI Awards with abstract submissions, poster and oral presentations. The turnout (virtual) was a credible showcase of all that has been achieved and a great celebration of the over-and-above efforts of the workforce. Deanery and health board leads formed part of the judging panel and enjoyed bearing witness to the varied achievements.
Karim Fouad Alber

Organisation: Oxford University Hospitals NHS Foundation Trust
Grade: ST5
Specialty: Acute internal medicine
Mentor: Dr Sudhir Singh

The chief registrar leadership programme was key in equipping me with the skills and knowledge to effect high standard quality improvement. Being able to connect regularly with other chief registrars and share both our successes and challenges was invaluable.

Point-of-care ultrasound in acute and ambulatory medicine.

Aim: To introduce and embed the use of point-of-care ultrasound (POCUS) in the acute and ambulatory care setting.

The project had several outcomes in the following domains:

1. Teaching and training:
Developed an in-house training programme, involving small group sessions and 1-to-1 supervision for professionals from different grades and disciplines (ranging from consultant, doctors-in-training, nurses and physician associates).

2. New equipment obtained:
Using charitable funds to obtain 11 new Butterfly iQ+ point-of-care ultrasound devices, as well as two new ultrasound cannulation training models.

3. Digital cloud storage and sharing
Working with the trust’s information governance and cybersecurity team, a cloud-based storage system for saving and sharing patient’s scans remotely was set up to enable remote review and sharing of images. This enabled practitioners to use POCUS in novel ways (eg by using it at the patient’s home while under the acute hospital at home team).

4. Governance and audit
Set up a regular POCUS governance for the department. These allowed for regular audit of handling of patient data (labelling and storage of scans) as well as cases presented for disseminating learning points.

The project leaves behind a POCUS-ready department. Over 200 scans were carried out, many of which resulted in enhanced patient care in ways that had never been achieved (such as performed at different locations, including patients’ homes, and sharing images with expert colleagues remotely for review). Moving forward, two consultants are being provided with dedicated time to continue supervision and training in POCUS.
Communication

1. Creating a ‘LIVE’ medical take list
2. Improving the REACTT pathway
3. COVID-19: setting up a virtual ward and rota management
4. Improving communication between emergency department and the acute assessment unit via MS Teams
5. Induction for IMTs and being ‘reg ready’
6. Implementing ‘You okay, doc?’ in the trust to provide mental health support to doctors (in progress)

1. The ‘LIVE’ medical take list helps to improve communication across the hot floor, allow consultants to have oversight on the take from anywhere, and has significantly reduced the workload for the navigators. It is accessed via NHSmail and OneDrive so meets security/confidentiality requirements.

2. The REACTT pathway is created for therapy assessment in the acute assessment unit (AAU) to facilitate discharge of patients with new injury/illness affecting their function or social presentation in a safe and timely manner.

3. The aim of the COVID-19 virtual ward was to reduce pressure on inpatient bed capacity while maintaining standards of care for patients who can be managed in their own home that are equivalent to those in hospital. The virtual ward is defined as a list of patients receiving remote management for a defined period of time, during which they will be monitored and receive protocolised remote follow-up consultations.

Patients monitored their own symptoms and observations at home using a pulse oximeter for regular review by a defined group of health professionals on a scheduled basis.

We successfully reduced attendances to hospital while highlighting those who required admission.

We also created an emergency rota in 24 hours for our colleagues.

4. We have conducted several inductions for new juniors and presented at ‘Call the medical registrar’ which prepares IMTs to become ‘reg ready’.

5. KS is an ambassador for ‘You okay, doc?’ – a mental health and wellbeing charity for doctors. The CEO expressed a keen interest to implement this across the trust. It is imperative we all look after one another, especially during this current climate, we must maintain our own physical and mental health so that we can give the best care to our patients.
Kevin Tsoi

Organisation: Maidstone and Tunbridge Wells NHS Trust
Grade: ST6
Specialty: Rheumatology and general internal medicine
Mentor: Miss Sarah Flint

By providing a structured way to tackle larger issues, the Chief Registrar Programme has allowed me to focus on quality improvement projects with more purpose. The opportunity to meet motivated senior trainees from different regions and to share ideas was invaluable. The programme provided us with the tools to take on time-pressured projects as well as encourage sustained change to improve patient care during a difficult second wave of the global pandemic.

Medical registrar ready programme

Aim: Stepping up as the medical registrar from senior house officer (SHO) grade is usually the next biggest change in responsibility as a trainee physician, after moving from final year medical student to FY1 doctor. According to the Joint Royal Colleges of Physicians Training Board (JRCPTB) guide to internal medicine training (IMT), ‘most trainees will be entrusted to manage the acute unselected take and manage the deteriorating patient with indirect supervision in IMY3.’ My main goal was to improve confidence levels in current IMTs with the above in mind.

1. Medical registrar ready programme

With the support of the local RCP college and associate college tutors, I ran a course for the IMTs focusing on developing the non-clinical skills required to successfully lead a medical take. Simulation scenarios typical of bleeps received by a district general hospital medical registrar were incorporated for added authenticity.

Feedback surveys comparing pre- and post-course confidence levels showed improvement in all areas. I now have approval to embed the programme into each IMT training year. Going forward, we also have the support from the HEKSS School of Medicine lead to make the course deanery-wide which I hope will be realised by my chief registrar successor with my ongoing support.

2. Medical registrar shadow COVID-19 rota working group

During the second wave of COVID-19 our trust suffered high sickness rates. Given the finite number of medical registrars, we had to find an innovative solution to maintain safe staffing in anticipation of last-minute sickness due to the more infectious variant. With the other higher specialist trainee representative, I set up regular medical staffing meetings to plan and formulate an emergency shadow registrar rota. Challenges included persuading key stakeholders that this would avoid further disruption to workforce, personal lives and wellbeing by planning for the unexpected. Together with the service managers and union representative, we ensured contract compliance and appropriate remuneration. The rota was successfully rolled out within a tight time frame during the second wave of COVID-19 and provided another layer of patient safety.
Lottie Elliott

Organisation: Aintree University Hospital (Liverpool University Hospitals NHS Foundation Trust)
Grade: ST6
Specialty: Emergency medicine
Mentors: Dr Dan Komrower, Dr Simon Mercer, Dr Rachael Ellks and Dr David Raw

The RCP Chief Registrar Programme has allowed me to appreciate further the running of the NHS, given me tools to navigate the system and inspired me to continue my leadership journey. Learning new models to implement change, how to deal with change barriers and how I personally react to change has been incredibly beneficial, especially in the ever-changing NHS. The training encouraged me to explore my personal traits, allowing me to understand how I react and deal with situations. Coupled with my existing knowledge from an MSc in medical leadership development, I feel very well equipped to deal with new challenges – especially looking ahead to my consultant post.

1. Filling a void in medical education
2. The implementation of NHS 111 First

Aim: The aim of the implementation of NHS 111 First was to develop a way to see patients quickly and effectively treated by the right person at the right time.

Involved in implementing the NHS 111 First in the trust, I regularly audited patient data to find presentation themes from which pathways were created and used by the 111 call handler to divert patients away from the emergency department (ED), for example by referring to a community service. The local results from NHS 111 First are pleasing, figures show that the number of patients directed to the ED has dropped, which means the pathways work in directing patients to other services instead of the busy ED.

Keen to fill the gap COVID-19 created in medical education, I set up a regular Zoom webinar entitled ‘Case of the fortnight’ discussing an interesting case and providing regular CPD. I also organised and chaired a junior doctor audit evening with great feedback.

The role of clinical educator in emergency departments was implemented at Aintree Hospital, funded by the trust. My work established that this role is popular and effective, noting it to be a worthwhile investment. I was delighted to present this work internationally at the International Conference on Emergency Medicine and be published in the Association for the Study of Medical Education (ASME’s) ‘The Clinical Teacher’.

Having realised break taking in the department did not reflect contractual standards, I started a campaign called ‘Gimme a break’ encouraging juniors to take breaks. This is a work in progress but I hope the awareness itself is a useful tool to allow juniors to get a break – a safety issue.

Other highlights included chairing Grand Round, contributing to a wide range of advisory groups, recording induction videos and attending board meetings.
A project team, aim statement and driver diagram were agreed. The project was introduced to one ward initially. Baseline data was collected (monthly number of bleeps for non-urgent tasks to ‘Hospital at night’ team, outstanding ward tasks at 5pm on Friday).

An afternoon checklist for nursing staff to complete was developed that highlighted outstanding tasks for their patients. The ward doctors then addressed those tasks before leaving at 5pm.

Initial uptake of the checklist was low. The team found that perceived workload, COVID-19 pressures, checklist availability and nursing engagement were responsible. Two folders for blank and completed checklists with an enclosed process map were introduced and replenished by the ward clerks. The ward sister became the nurse champion for the project after colleagues reported a fall in nursing workload over the weekend period.

There was a reduction in the bleeps to ‘Hospital at night’ from baseline 65 tasks per month to 21 the month after the checklist was fully operational.

Due to the successes above, the project was rolled out to an adjacent ward with a similar reduction in tasks. Expansion across all wards is in progress. Staff experience of the project has been positive.
As chief registrar, I chair the junior doctor body (JDB). Through a communications campaign, I was able to increase membership of the JDB from 12 to 32, spanning most specialties, representing training and non-training grade doctors.

Within the JDB, I was able to share research and QI opportunities, including recruiting 50 juniors to be involved with COVID-19 vaccination research. Members were able to cascade information about the different QI collaboratives, so the wider junior workforce could get involved. Executive team members were invited to speak and share their roles with members, increasing communication between juniors and senior executive team members.

Focus groups were set up to help understand what juniors would like within their future job roles as consultants, to help recruit and retain the very best trainees in the future.

We listened to juniors and were able to provide rest facilities in most wings of our hospitals, improving their health and wellbeing. We worked closely with the wellbeing champions and professional support unit, to support juniors in departments struggling with COVID-19 burnout.

We trialled different communication strategies, including a new app; however, feedback suggested short, succinct junior doctor digest emails were appropriate. Our most recent edition will share a video of our virtual junior doctor and dentist awards for 2021 – a really great celebration to share before juniors rotate.

I am committed to completing my Kaizen lean for leaders training, to continually improve the sexual health services I work within.
The new internal medicine training programme replaced the core medical training programme in August 2019. One of my main projects as chief registrar was to lead on implementation of IMT3 year at the Glenfield Hospital Leicester starting in August 2021. This meant establishing nine posts of a brand new role of junior medical registrar in five different medical subspecialties based at Glenfield Hospital. It was particularly challenging as these posts were created from existing resources, since no new funding was available. I worked with the departmental leads, HR, workforce and quality improvement teams. I represented and voiced the junior doctors at various forums. I feel lucky to have had excellent support from my peers and mentors. The chief registrar training programme has been brilliantly structured and delivered. I feel more confident to soon become a consultant as I am definitely more knowledgeable in quality improvement, leadership and management domains.

Other projects:
- Electronic staffing (Medirota) implementation in respiratory medicine at Glenfield Hospital
- Virtual junior doctor forum at Glenfield Hospital
- One-week micro taster specialty experience for junior doctors interested in respiratory medicine as their future specialty
- Glenfield junior doctor senate – a forum for junior doctors offering leadership and quality improvement experience at Glenfield Hospital

The new internal medicine training programme replaced the core medical training programme in August 2019. One of my main projects as chief registrar was to lead on implementation of IMT3 year at the Glenfield Hospital Leicester starting in August 2021. This meant establishing nine posts of a brand new role of junior medical registrar in five different medical subspecialties based at Glenfield Hospital. It was particularly challenging as these posts were created from existing resources, since no new funding was available. I worked with the departmental leads to establish the IMT3 doctors’ roles and responsibilities and formulated a comprehensive induction booklet which will serve as a guidance document for the current IMT3 doctors as well those joining in future. I worked with the medical workforce and HR teams to design the IMT3 on-call rota and their daytime job plan, including training and education sessions in their subspecialties. Regular meetings were arranged to ensure the posts are all set up for trainees to have a seamless start. Virtual IMT3 induction was arranged as pre-recorded talks which were made available for online attendance.

A year passed so quickly being involved in such an incredible leadership experience through the challenges of the COVID-19 pandemic. It has been really insightful to understand the NHS as an organisation with so much more happening besides the clinical shop floors. I worked closely with the departmental leads, HR, workforce and quality improvement teams. I represented and voiced the junior doctors at various forums. I feel lucky to have had excellent support from my peers and mentors. The chief registrar training programme has been brilliantly structured and delivered. I feel more confident to soon become a consultant as I am definitely more knowledgeable in quality improvement, leadership and management domains.

Implementation of new IMT3 year posts at Glenfield Hospital Leicester

Aims:
1. Establishing IMT3 posts at Glenfield Hospital Leicester out of existing resources to ensure a seamless start in August 2021.
2. Designing a comprehensive job plan for IMT3 doctors at Glenfield Hospital and a bespoke on-call rota focused around IMT curriculum needs.
The RCP chief registrar training provided an insight into the theory behind medical leadership and gave me a platform to reflect upon my own leadership skills and identify specific areas for development. It also introduced me to an exceptional network of young clinicians who are motivated to influence change through quality improvement. I was able to use my time as a chief registrar to respond to local challenges ranging from developing wellbeing and training opportunities for junior doctors to establishing a trust-wide multidisciplinary virtual teaching programme. It was a privilege to have the chance to make changes to promote patient safety and improve the patient experience.

Improving the junior doctor and patient experience

**Aim:** To improve the patient experience and promote the wellbeing and training of junior doctors.

I designed/managed the COVID-19 incident rota for >130 junior doctors working across 30 wards. I generated a multi-layered support network to minimise the impact on wellbeing and used this as an opportunity for trainees to develop leadership skills. Junior trainees were appointed as ‘team leaders’ and promoted wellbeing alongside their organisational roles. Weekly team leader meetings provided mentoring and peer support and led to the establishment of wellbeing events. Team leaders felt they developed their leadership skills, with 66.5% considering applying for formal leadership training.

I developed a trust-wide weekly virtual teaching programme for doctors, nurses and AHPs. Teaching sessions are recorded and uploaded to create a teaching resource. There has been engagement and interest for over 6 months, with appreciation of its inclusive and multidisciplinary nature.

To comply with Resuscitation Council UK guidelines, I initiated a daily cardiac arrest team briefing meeting. Allocating team roles instilled a sense of teamwork, allowed contingency plans to be made for simultaneous arrest / medical emergency calls and improved team members’ confidence.

In collaboration with the lead physiotherapist, I gained support from the CEO for intra-dialytic exercise and secured funding for over-the-bed cycles to allow patients to continue rehabilitation and improve cardiovascular fitness while on haemodialysis.

A current challenge in providing a good patient experience is to preserve the clinician–patient relationship while reducing footfall within the hospital. My study aims to identify whether we are meeting the needs of patients / healthcare providers, identify areas for improvement, then develop strategies to augment the patient/clinician experience of virtual consultations.
The chief registrar leadership development programme has given me the time, authority and support to understand how change happens in the NHS and to learn how to achieve that change first-hand. Further, the RCP Chief Registrar Programme for me was an incredible opportunity to do this as a trainee and with the full support of division of surgery and the RCP.

I have concluded that the chief registrar post is not for everyone. However, for those who aspire to change and improve the part of the medical world they inhabit I can think of no better model for gaining experience.

**Same day emergency care (SDEC)**

**Aim:** To seek and exploit incremental efficiency gains in clinical pathways in order to increase the number of patients receiving same day emergency care (SDEC) in emergency general surgery (EGS) at Queen’s Medical Centre (QMC), Nottingham.

EGS in Nottingham is integrated with one of the largest ED departments in the country and sees an average of 8,491 patients per year in a dedicated surgical triage unit and EGS ward. The unit aims to provide safe, effective and efficient care to those in need. Constant strains on resources and increasing admission numbers mandate that efforts to achieve efficiency are paramount.

As the first chief registrar for surgery, I was tasked to focus on EGS and specifically measures to improve SDEC. I also worked with the medical educational team and junior doctors’ forum, plus I completed some work on governance and compliance with DNACPR. In total I was involved with 15 quality improvement projects. These included digital pathways, live emergency general surgery data and dashboards, electronic referrals, digital clerking, guidelines, pathways redesign, interactive handbooks, online induction, establishing an ED interface group and ring-fenced CT and ultrasound. With each project I learnt something new about the people and systems we work within and became the relay between the management and clinical staff.

I left the year with demonstrable improvements in SDEC thanks to the many people who work within EGS. Historical SDEC was 45%. During my tenure EGS saw month-on-month improvement in SDEC to 66%, despite a 33% increase in referrals. No increase in readmissions was observed. This increase in SDEC equates to annual savings of £960,624 assuming historically this patient group had an overnight stay.
Oluwadamilola Bamigbade

Organisation: Hull University Teaching Hospitals NHS Trust (HUTH)
Grade: ST7
Specialty: Paediatrics
Mentor: Dr Makani Purva

The teaching days taught me the required quality improvement project (QIP) methodology required to successfully plan and action my QI project. They also gave me the opportunity to understand my personality type, communication style and other leadership and management skills. I learnt how these could be used to effectively lead a team (with different personality attributes) to achieve a common goal. These skills proved valuable during the second wave of the COVID-19 pandemic when understanding of clinical pressures and the need to still deliver the project aim was required.

Stop the line
Aim: Increase the reporting of ‘Stop the line’ events (‘near misses’) by 50% over a 6-month period.

I took on my main project, ‘Stop the line’ from my predecessor. The project aim was to educate and encourage staff to report more ‘Stop the line’ events (‘near misses’) – developing a safety-II culture. The project has been implemented in 4–6 clinical areas. Reporting has increased, but not up to the 50% target. Barriers to reporting have been identified, ie COVID-19 ward pressures and lack of education. These are currently being addressed.

Some of the other projects I have been involved in include:

- Creating patient experience videos for the monthly trust board meeting. These showed the effect of COVID-19 on patient experience (ie waiting times, visiting rules) through different services in the trust. Despite current pressures on the NHS, the majority of interviewed patients were grateful for the care being provided by HUTH.

- Coroner’s statement QIP – interventions were implemented (hiring staff, new electronic record system, traffic light spreadsheet) improving the process of submitting statements to the coroner, allowing the trust to meet the 12-week deadline. A 16% improvement has been seen.

- QIP committee – providing feedback (on methodology and whether the project would yield beneficial results for the trust) on QIPs submitted by staff.

- I contributed to the phlebotomy business case (phlebotomy survey and report) to reduce pressures on junior doctors and allow time for other training opportunities by hiring more phlebotomists.

Lastly, as a result of the projects done, I came second for the ‘junior doctor of the year’ award at HUTH. Four posters have been accepted for virtual display at the Health Service Journal (HSJ) patient safety congress.
Ramsay Tabbara

Organisation: Whipps Cross University Hospital, Barts Health NHS Trust
Grade: ST5
Specialty: Cardiology
Mentors: Dr Heather Noble and Dr Saurabh Chaudhri

Working as a chief registrar under COVID-19 restrictions presents many additional challenges and barriers. In spite of this, the RCP training programme was invaluable in giving me the skills needed to allow my projects the best chance of success. Their training and the mentorship from my local leaders helped me to understand myself better and hence more clearly define my own leadership and communication style. Access to the advice and support of senior leaders in my organisation helped me to develop these skills further and enabled me to see how our work fits into the bigger picture.

1. COVID-19 preparation: responding to site needs
2. Improving safety and continuity of care through an improved handover process

Aims:
1. Deliver targeted intervention in training, rota design and resource tracking to improve staff working experiences under COVID-19.
2. Improve systems of recording acute admissions and improve management of patients transferring between acute admission and medical wards out of hours.

Project 1:
I identified key areas for intervention: tracking of aerosol generating procedures (AGP), training for staff who had little experience managing COVID-19, improved access to resources, redesigning the model of cover to provide a less intense rota and improved distribution of information.

I implemented a system of manual AGP tracking undertaken by medical SpRs during the first COVID-19 wave. This was replaced with an automated system using information logged in patients’ electronic records, which allowed reliable provision of data to help with daily operational decision-making and higher-level COVID-19 planning.

I designed a programme of COVID-19 training to include the latest evidence-based updates and to upskill staff in the use of AGPs. We provided a centralised store of resources available via an app through which regular site-specific updates could be provided. This allowed easy distribution of key messages or guideline updates.

Project 2:
Medical teams were encountering issues with the location for handover meetings and with the system for recording medical admissions. A new designated space for medical handover was identified and we built a new electronic take database for medical/surgical admissions. Our sign-in process was also made paperless and a clear agenda was provided.

A new system of handover for patients moving between acute/speciality wards was enacted based on the RCP acute care toolkit. Patients who move from acute to specialty wards over weekends often have ongoing medical needs, so a dedicated team was set up to review any patient moving away from admission wards over weekends. We designed an automated list drawing data from electronic patient records to identify the patients who had moved.
Rebecca Thom

Organisation: King’s College Hospital NHS Foundation Trust
Grade: ST6
Specialty: Renal and general medicine
Mentor: Dr Dan Wilson

I have been lucky to be a chief registrar at my local hospital and witnessed first-hand the clinical teams rising to considerable challenges they have faced in the past year. The chief registrar leadership and development programme has given me the tools that I needed to understand how I, both as a trainee and future consultant, can learn from and respond to the needs of the local community. It has also helped me reflect and focus on what is important to me as a leader, team member and even potential patient. I have gained skills and insights which I hope will serve me and my patients well in my future career.

Aims:
1. Redeployment of junior doctor staff to safely manage the increased demand on general medicine from the COVID-19 pandemic.
2. To improve the quality of medical handover through a series of trainee-led initiatives.
3. Modernising medicine is a major strategic project to transform the way acute and general medicine is delivered at King’s.

Like many of us, there are things I would like to have achieved this year which fell by the wayside. However, one of the beautiful things about being a chief registrar is that even when you feel like you are not achieving what you set out to you are learning and developing in ways you wouldn’t have anticipated. These three projects reflect the breadth of experience a chief registrar might expect to gain throughout their year. Each one has taught me different perspectives and strategies.

A project like redeployment is time limited, working on my own or in small teams, researching, developing a plan, taking initiative and making independent decisions. While it is daunting to take on a project like this it also teaches you a lot about your capabilities. Improving handovers meanwhile was a project which incorporated disparate, junior doctor led initiatives, observing the effects of different interventions over the whole year.

Finally, modernising medicine is a trust-wide project involving a large multidisciplinary team (MDT), project managers and clinical leaders into which I was able to feed the perspective of junior doctors. Involvement in this project gave me a wider perspective of how quality improvement is achieved and managed on a much larger scale than one would usually see as a junior doctor.
Rupert Bright

Organisation: Imperial College Healthcare NHS Trust
Grade: ST5
Specialty: Renal and general medicine
Mentor: Professor Frances Bowen

The RCP Chief Registrar Programme has allowed me to take the next step forward in my medical leadership and management journey by combining a formal training programme with the daily hands-on experience of working with the senior leadership team and patient-facing clinical and admin staff at Imperial. Being able to apply the knowledge and skills learnt in practice empowers you to take on new challenges that previously may have seemed insurmountable and where attempts at change may have failed previously. The comradery of being part of the chief registrar cohort has provided a great support network for collectively addressing the challenges of the junior doctors and the wider NHS during the COVID-19 period.

Empowering junior doctor leadership at Imperial

Aims:
1. Junior doctor involvement at all levels of the organisation.
2. Better communications and engagement with junior doctors.
3. Engagement of trainees with divisional development priorities.

Through what has been arguably one of the most challenging years in NHS history it is has been a privilege to be the first chief registrar at Imperial College Healthcare.

During my time as chief registrar I have worked to bring junior doctor input and engagement to all levels of the management structure at Imperial. This has been especially valuable during COVID-19 surge activity and periods of redeployment. This has included:
1. being a member of the clinical reference group tasked with rapid clinical policy development and decision making during this time of unprecedented change
2. developing and implementing new medical rotas for junior doctors and the introduction of IMT3 trainees
3. being part of the senior management team and taking a central role in the organisational planning and response to COVID-19.

Equally important has been recognising the incredible work and commitment of junior doctors during the COVID-19 period. Through increasing the use of ‘make a difference’ recognition awards for junior doctors, involvement in the trust COVID-19 legacy programme and providing a supportive environment for junior doctors on a day-to-day basis, their experience has been enhanced.

To increase trainee involvement in QI and management post-COVID we have recruited four divisional junior doctor representatives who sit on the management committees and will act as a link between the senior management team and juniors in clinical areas. They will work together with future chief registrars to deliver divisional priorities in partnership with junior doctors.

Trust-wide junior doctor communications has been a longstanding problem and I have developed and implemented a dedicated junior doctor intranet homepage that automatically provides junior doctors with the most relevant and up-to-date trust information. I have also developed resources and communications around doctors’ role in patient flow and discharge planning that has improved board rounds and ADD documentation.

During the year I have also been an integral part of two key trust-wide transformation programmes – first being the implementation of a bleep replacement app which required significant technical and staff engagement work. I was a member of the procurement group for the application and now the trust-wide implementation group.

Second being co-development of a pioneering new electronic rostering system in partnership with Patchwork Health. I have used my experience in the development of a ‘personalised rostering’ solution in the trust to develop this new product with the Patchwork developers.

Finally, as part of my work in general medicine I have developed and implemented virtual weekend medical handover that has increased weekend discharge numbers, patient safety and junior doctor experience.
Ruth Carter

Organisation: Oxford University Hospitals NHS Foundation Trust (OUH)
Grade: ST5
Specialty: Emergency medicine
Mentor: Dr Sudhir Singh

The chief registrar leadership development training has helped me better understand myself and others around me. It has been a privilege to be involved in the programme and to witness first-hand the struggles and triumphs of leadership in such a large NHS organisation. Working as a chief registrar in 2020/21 has been particularly interesting with the context of a global pandemic, and I remain inspired and humbled by the versatility, ingenuity and positivity of so many NHS colleagues. Thank you to all at OUH and the educator team at RCP.

1. Reshaping internal communication in the emergency department (ED)
2. Using quality improvement methodology to redesign initial assessment and flow of ambulatory adult patients within the ED

Aims:
1. Develop and embed an online platform to enable two-way communication, collaboration and learning within the ED clinicians team, eliminating the necessary use of personal social media for professional communication.
2. a Develop a process with suitable estate and workforce to appropriately manage the high volume of ambulatory patients presenting to the ED.
   b Reduce the time to initial assessment for ambulatory ED patients.
   c Maintain timely care and departmental flow within the ambulatory cohort, despite bed pressures and congestion affecting other areas of the ED.

1. Established platform for communication, sharing and online teaching with the scope to grow and change with the organisation. This has reduced the need for ‘workplace Whatsapp’ and given clinicians more control over how and when to mentally engage with work, improving ease of access to information and resources while reducing staff fatigue through never being able to ‘get away’ from it.
2. The work on flow has led to some objective achievements – primary the significantly reduced time to assessment, shift in departmental mentality from majors/minors to trolley/ambulatory, and embedding of new, focused clinician roles and allocations to prioritise timely decision making and care. However, the main achievement seems to be through demonstrating the benefit of working together within a multidisciplinary team (MDT) group with the aim of achieving change to benefit the ED and patients within. This has led to a greater sense of unity and team within the department and facilitated a large number of smaller, yet important, interactions.
Ruth Whitaker

Organisation: Western Health and Social Care Trust, Northern Ireland
Grade: ST5
Specialty: Respiratory and general internal medicine
Mentors: Dr Neil Black and Dr Girish Shivashankar

The stepwise framework of learning through the chief registrar year allows for projects to be initiated and then progress and improvement monitored incrementally, while also allowing time for personal reflection and development. I was the first chief registrar within the trust. Having a recognised RCP role and being an ambassador for the programme has allowed me to make introductions to multiple groups of clinical and non-clinical managers and directors and provided me with a greater overview of the NHS structure and my future role within it.

1. Establishing the ‘fluid vigilance team’ – improving IV fluid safety within the trust
2. ICU discharge debrief clinic service – assisting to establish a clinical follow-up service for ICU survivors

Aims:
1. To improve the accuracy of IV fluid prescriptions and to improve the engagement with, and accuracy of, fluid balance monitoring charts.
2. To assess which patients would most benefit from ICU outreach follow-up following discharge from critical care and to implement a structured virtual ward service list for their needs.

My fluid vigilance team (FVT) project has allowed me to learn the important methodology of QI, my role as a leader and as a team member when supporting other leaders in turn. We developed a ward-based team of educators and ambassadors to introduce cascade learning and to maintain high standards of clinical care, leading to better monitoring, accurate prescribing, more patient involvement in the medical journey, improved satisfaction from team members and pride and recognition for their improvement results.

The ICU project allowed me to exercise more managerial skill, rallying a team and setting deadlines for each step of the journey. The project aims to identify patients needing the most intervention post ICU discharge. Some of the audit data analysis is ongoing and the restrictions of ICU/COVID-19 redeployment have been significant limitations.

Other projects have been running alongside simultaneously. Observing and engaging in decision-making managerial roles, including taking a position in the hospital’s ‘COVID-19 doctors’ hub’ (prioritising junior doctor welfare and ward cover/redeployment) has been an invaluable experience and the doctors’ hub team members became firm friends and fabulous role models of response in action.
Saad Qutab

Organisation: East Sussex Healthcare NHS Trust
Grade: ST5
Specialty: Respiratory medicine and general internal medicine
Mentor: Dr Simon Merritt

The insight into my own skills, of which some were unpolished and some unknown, has been exciting. On one hand I have tasted how things operate at an organisational level and have learnt about NHS structure, and on the other hand with my six QIPs I have managed to bring about measurable improvement which has been welcomed by most. Besides polishing my leadership skills, learning about the human psychology of leadership and leadership styles has been an achievement. I am grateful to my supervisor (chief of medicine) for his excellent role modelling.

Introduction of standardised pre-weekend/Friday ward round proforma

Aim: Structured and effective handover with a focus on time efficiency, patient safety, ceiling of care, resuscitation status and Friday checklist.

When I started the chief registrar role there was a mixture of emotions – apprehension of the unknown and excitement for learning something new. As I established myself in the role the apprehension was replaced with responsibility – of leadership, seniority and expectations. And while I was weighing up different ideas to select a project from, COVID-19 struck again and all the brilliant ideas came crashing down when the role became 100% clinical. Combine this with an offer of new out of programme experience (OOPE) taking full 2 months away, suddenly the time was running short and running fast. A light bulb moment – there were opportunities here.

A new rota needed to be made which was practical, flexible, ensured patient safety, distributed work equally and was easy to implement. Also, there was a need for an effective handover from week team to weekend team. Timely decision-making regarding resuscitation and escalation plans was needed more than ever.

I started by designing the projects, recruiting a team of motivated individuals, drafting the rota and proforma, engaging stakeholders, making amendments and finally piloting the projects. Invaluable guidance came from supervisor meetings, RCP modules and PDSA cycles and, learning through each, we managed to deliver on both projects with flying colours. Reflecting back, new learning has been about organisation, effectiveness and leadership, time management, NHS structure and management etc. Also, collectively it’s the small things having a bigger impact than a rare big bang.
Salam Al-Alousi

Organisation: University Hospitals of Leicester NHS Trust (UHL)
Grade: ST6
Specialty: Acute and general internal medicine
Mentor: Dr Lee Walker

The RCP Chief Registrar Programme allowed me to take advantage of the numerous opportunities the COVID-19 pandemic presented – improving my leadership skills, engaging with and learning from senior leaders in the trust and allowing time to work on projects to improve junior doctor satisfaction and teaching (particularly for PACES). It has been a valuable and rewarding experience with many skills learnt that I hope to continue using in my professional career.

1. IMT clinic weeks
2. Virtual emergency specialist medicine induction for junior doctors
3. Junior doctor COVID-19 update meetings

Aims:
1. Pre-arrange clinic allocations for internal medicine trainees during their intensive therapy unit (ITU) rotations.
2. Transform directorate induction for junior doctors from face to face to online and virtual to accommodate COVID-19 restrictions.
3. Update junior doctors on trust plans for COVID-19, as well as COVID-19 literature update.

1. During their ITU rotations, internal medicine trainees are offered 2 weeks to attend medical clinics. Often trainees have struggled to arrange clinics and utilise this time effectively. We pre-arranged a balanced selection of clinics and ensured clinic coordinators and consultants were informed of attendances. We also created a medical clinic index with contact details to help trainees arrange alternative clinics if required. Feedback has been excellent, both from trainees and ITU consultants.

2. Three times a year, our trust has a face-to-face induction for newly joined junior doctors. Due to the COVID-19 restrictions, myself and junior doctor administrators rapidly transformed this to an online virtual format with introduction of pre-recorded videos for those speakers who were unable to attend live. We successfully maintained and then improved on the quality of the material delivered by collecting and acting on feedback. A poster of our work was presented at the Society of Acute Medicine Conference in April.

3. Listening to junior doctors it was clear that communication could be improved with regards to COVID-19 plans made by the trust. An infectious disease registrar and I delivered COVID-19 junior doctor update meetings online twice a month to discuss any trust updates and new information on COVID-19 from research/literature, often with guest speakers. I attended daily COVID-19 strategy meetings and was able to feedback concerns from junior doctors to these meetings, acting as their representative. These meetings were well received and offered moral support.
Sarah Packer

Organisation: Worcestershire Acute Hospitals NHS Trust
Grade: ST6
Specialty: Geriatric medicine
Mentor: Dr Jules Walton

Being a chief registrar has opened more doors than I ever thought possible. It has given me a huge insight into my own character as well as the wider workings of the NHS, equipping me with the skills I need to be a medical leader of the future. I have a greater insight into the world of those who work alongside us but outside the clinical environment. I have seen the diversity of our junior doctor workforce and their strength in the face of great adversity, as well as advocating for and supporting them through the second COVID-19 surge.

Listening and leading: a bridge between junior doctors and senior management through COVID-19 and beyond

COVID-19 redeployment
I managed junior doctors redeployed to work within our COVID-19 surge wards. I ran induction, provided daily troubleshooting and ensured they were deployed to the places in greatest need, where they provided invaluable support, making the service safer for patients and workload more manageable for staff.

Sepsis 6
I joined the trust sepsis working group to improve compliance with the sepsis 6 for medical inpatients. I surveyed junior doctors and reviewed case notes to identify barriers to compliance. I developed a video to plug an identified gap in training and presented at induction. I presented this QIP to the Quality Governance Committee and trust board.

Registrars’ forum / electronic referrals
I led monthly registrars’ forums alongside the RCP college tutors. One concern raised was the frequency of bleeps to the medical registrar, many of which were routine referrals. These calls interrupt key duties of the medical registrar, making the role more stressful and less effective. I have liaised with key stakeholders to start developing an electronic referral pathway, saving time for medics and ED doctors alike. I have identified a successor to continue this project, which has the potential to greatly improve the medical registrar’s role.

SIM
I was a key faculty member for our inaugural thrive simulation course for IMT doctors, which received universally positive feedback.

In conclusion, this year has changed me forever. I go forward more confident, more effective and more determined, and I hope this is just the beginning of my involvement with the RCP.
Patients referred by primary care to GRH were historically admitted to the emergency department (ED) in an unorderly fashion, making it challenging to locate and assess patients. An audit in GRH showed only 31% of patients were reviewed by a consultant within 14 hours. We introduced a general practitioner priority assessment unit (GPAU). GPAU is a designated area within the ED where patients referred by primary care are directly admitted and so geographically located in one area.

With GPAU 100% of patients were seen by a doctor, 72% of these were seen by a doctor within 1 hour of arrival. The implementation of GPAU significantly improved the length of time before patients were seen by a doctor upon arrival to the hospital. There is an opportunity to use side rooms in GPAU for specialty clinics to help facilitate admissions or potential discharges. GPAU allows for patients to be triaged rapidly with prompt treatment initiated. This model can be replicated nationwide, ultimately improving patient safety.

During the COVID-19 pandemic, I also worked closely with senior managers to close the gap between them and junior doctors. Channels of communication were opened with the implementation of weekly junior doctor calls with the medical directorate team, wellbeing drop-in sessions and opportunities to gain workplace-based assessments for trainees while on challenging rotas. This inclusive approach has significantly changed the culture of our trust and due to its success, these interventions will continue.
Improving response to observation alerts

Incident reports showed significant delays in response to Nervecentre NEWS observation alerts. Through formation of a working group, engagement of stakeholders and focus groups, several PDSA cycles were performed. Response time reduced by 86.7% and continues to improve, enabling enhanced surveillance, classifying severity of illness, improved triage and ultimately reduce hospital mortality and cardiac arrest.

Improving care of medical outliers

Being a medical outlier increases your length of stay compared with a patient in a medical bed base. In line with trust strategy, the working group I established improved the current structure and management of medical outliers. Following early successful interventions, an escalation map was devised in line with trust acuity and OPEL scoring – the first in the area – and will be shared with other trusts regionally for best practice. Future successes will be a unique team office space and cohorting patients by expanding the medical bed base.

Introduction of geriatric JDF

Informal meetings focusing on improving wellbeing, clinical effectiveness, openness and culture provided a platform to address trainees’ concerns. This included an induction manual, improved leave, physical and virtual access to teaching, enhanced exception reporting and SHO clinics.

A final success was the funding and creation of an office space for junior doctors on the COVID-19 ward.

Although COVID-19 challenged many projects, I have gained an invaluable insight into the challenges faced by senior management dealing with complex cultural change, institutional tribalism, motivating and inspiring the junior workforce and the necessary skills to effect change.
The main project I was involved in was the piloting of the older person’s emergency department (OPED). In the fast-paced emergency department, the comprehensive physical, social, cognitive and situational needs of the older person are often not met. We piloted OPED, wherein patients who were deemed to be frail or over 85 years of age were simultaneously assessed by a multidisciplinary team – an ED clinician, a frailty practitioner, an occupational therapist, and input from an interface geriatrician consultant or registrar, if required.

Our admission rate in this cohort of patients reduced from 83.8% to 76.5%. Our readmission rate reduced from 6.3% to 4.4%. Length of stay in ED was reduced by 41 minutes.

The trust has recognised this as a successful pilot and will be implementing it in the future.

Older person’s emergency department

Aim: We piloted the older person’s emergency department to provide multidisciplinary, comprehensive management to the geriatric patients presenting to A&E.
Sommer Lang

Organisation: Somerset Foundation NHS Trust
Grade: ST5
Specialty: Geriatric medicine
Mentors: Vikky Morris and Matthew Hayman

My year in the Chief Registrar Programme has been enlightening. I never imagined I would have the opportunity to not only gain insight into how a trust works, but also be invited to actively participate in and strive to achieve lasting improvement. This year has given me the skills and the confidence to get involved, ensure junior doctors’ voices are heard, and work to create sustainable change as a means to provide safer and more effective care to our patients and enhance training opportunities for trainees.

QI for junior doctors

Aim: In the period August 2020 – August 2021, only 36 of 256 junior doctors in training posts at Somerset Foundation Trust (14%) had QI training within the trust. Most junior doctors do not feel supported to undertake a QI change project. We aim to increase the number of junior doctors at Somerset FT undertaking/completing a QI project from 14% to 85% by August 2022.

When I applied to be a chief registrar, I did not consider that we would still be knee-deep in a pandemic. Despite this, the importance of every person’s involvement in making lasting, sustainable change that better cares for our patients and staff has been highlighted throughout these particularly challenging times. In response, my project was developed to equip junior doctors with the skills and confidence to see a problem, gather a team and make a plan to implement change to provide better, safer care. We must all participate in quality improvement to tick a box in our portfolio, but few of us have been taught the skills, and even fewer understand the relevance and meaningful impact that they can make.

I had the opportunity to speak to senior leadership staff to emphasise the value of junior doctors. It stressed how important their voices are and what a wealth of ideas they can provide to make valuable change. This was fully accepted and encouraged by those in leadership.

With the team on board, we began to expand Bronze QI training to all junior doctors. Starting with a small group of representatives from various training programmes, we identified barriers and came up with ideas to overcome them. As a result of positive feedback, we have now introduced Bronze QI training for all our IMT and FY2s, with the hope of expanding to surgical, obstetric, mental health and paediatric trainees later in the year.
As a 2019/20 chief registrar, my original planned projects were halted by the onset of the COVID-19 pandemic. As I was on the government shielding list, it was even more challenging to perform a leadership role while working from home. The uncertainty that came with the first wave brought with it much anxiety for many staff groups and highlighted the importance of psychological support. I was part of a team that developed a network of ‘psychological first aiders’, available to all members of staff and offering both a ‘drop-in’ and ‘call-in service’.

As the numbers of COVID-19 cases began to rise, I was tasked with writing ‘green, amber, red and black’ rotas to ensure that patient safety was not compromised during such an uncertain time.

I was part of an effort to ensure that staff had been tested on the appropriate PPE and gather key information that informed its further acquisition.

I was able to help set up direct communication between the doctors and senior management, allowing for rapid and dynamic response.

I collaborated with a group of chief registrars from nine different trusts, producing an article about our experience as middle leaders, published in *Future Healthcare Journal*.

I was part of the trust culture and change team, focusing on patient experience. I analysed thousands of patient feedback forms against national criteria to gauge both areas of strength and for improvement. I was able to set up patient focus groups to get input to further direct change.

The RCP Chief Registrar Programme has further unveiled the backstage workings of an NHS trust, and given me the platform to act as a link between senior management and junior staff. It has provided a new perspective on leadership skills, which will undoubtedly allow me to view future challenges with a far broader lens.

**NHS staff wellbeing during the COVID-19 pandemic**

**Aim:** To establish a network enabling all staff groups to access psychological support.
Being a chief registrar during the pandemic has certainly been a career-defining opportunity. I have witnessed great examples of leadership during a crisis and the RCP leadership development training has helped to underpin the core values of NHS leadership and organisational structure. It has been a journey of self-discovery. Psychometric tests and sessions on resilience and emotional intelligence during the development training have helped me to deal with the challenges and obstacles of being a ‘middle leader’ during the pandemic. The chief registrar leadership development training programme has helped me build on and improve my negotiation skills. This has been very valuable, given my involvement in COVID-19 workforce planning and balancing redeployment with junior doctor wellbeing and training.

Main project:
Tomorrow’s leaders – a leadership and management programme for middle grade doctors

Additional projects:
1. Joint medical and surgical ‘Hospital at night’ handover to improve patient safety and enhance out-of-hours working
2. Developing and implementing electronic medical handover to improve weekend handover processes
3. Responding to COVID-19 – workforce planning and junior doctor wellbeing

Aim: To design and deliver a blended educational programme on leadership and management for middle grade doctors through a 3-day structured training programme and a manager–buddy mentoring scheme.

Current higher specialty training programmes heavily focus on gaining the clinical skills required to be a safe and competent clinician. However, it is much more difficult to obtain important non-clinical skills around leadership and management during training. With this in mind, I set out to design and deliver a leadership and management programme for middle grade doctors in our organisation (open for both training and non-training/SAS doctors).

I organised a 3-day structured leadership and management programme called Tomorrow’s leaders, which ran during my chief registrar year. I invited senior leaders in the organisation to help me facilitate sessions on face-to-face, socially distanced training days. These days included a mixture of pre-course preparation and reading, formal lectures, small group work on case studies and live Q&A sessions with the CEO, medical director and trust board members of the organisation. This programme offered a unique experience for delegates to understand NHS leadership and management at a granular level.

With 20 delegates attending each day, the programme has been a great success and I have received very positive feedback. All delegates found the course valuable and supported embedding such programmes into higher specialty training. Several delegates opted for the manager–buddy scheme, in which the delegate was matched with a senior leader or manager in the organisation and got an opportunity to receive some one-to-one mentoring and gain insight into leadership and management in action. As a result of this project, delegates felt empowered to undertake formal leadership and management roles in the future.
Yang Chen

Organisation: St Bartholomew’s Hospital, Barts Health NHS Trust
Grade: ST5
Specialty: Cardiology
Mentors: Mark Westwood and Edward Rowland

The RCP chief registrar training programme was a great blend of curated resources and facilitated peer discussion, with advice and feedback that was directly helpful to our projects and hospital activities in general.

Working as a part of a pair of chief registrars with different medical backgrounds at St Bartholomew’s Hospital was very useful, given the highly specialised work and ‘top-heavy’ make up of junior doctors at the hospital.

Fostering an educational environment and psychologically safe community – all delivered online – offered a central pillar to sense-check ideas and support our training and wellbeing throughout the year.

Distributed leadership opportunities across the hospital site

Aim: To offer a proactive approach to junior doctor wellbeing through greater opportunities to work alongside hospital leadership and gain new experiences.

Like other projects this year, being flexible and responsive to the COVID-19 pandemic meant that progress was stop-start. However, with the support of senior colleagues at the hospital site, we made significant progress in terms of building stronger links between the unique group of junior doctors at St Bartholomew’s Hospital and the consultant and wider leadership workforce. We:

- established regular communications from the ‘chief SpRs’ and a repository of useful contacts, and answers to FAQs, eg regarding audit or QI registration, use of the electronic health record
- showed evidence of distributed leadership during the winter wave of COVID-19 – fellow SpRs stepped up and worked in a flattened hierarchy as part of clinical working, as well as service planning
- created opportunities for future junior doctor leadership growth, including a pilot fellowship for two SpR colleagues with Deloitte UK, after networking and collaboration with the director of medical education and hospital executive team, including our head of finance
- developed plans, now underway, to sketch out a more sustainable framework of leadership opportunities, including ways to include more ‘institutional memory’ in the chief registrar post at St Bartholomew’s Hospital, as well as links to other RCP initiatives, eg closer collaboration with the associate college tutor network.
With thanks to the following 2020/21 chief registrars who were unable to participate in the yearbook:

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The RCP Chief Registrar Programme
2020/21 yearbook

For further information
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