



▶ Lessons Learned - Educating Doctors in Training on Clinical Governance & Serious Incidents

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ST4 Acute Internal Medicine

What we are going to cover

- ▶ **WHY** this project
- ▶ **WHAT** I wanted to achieve
- ▶ **WHAT** I did
- ▶ **WHY** you should care
- ▶ **WHAT** I learnt

WHY This Project



The Current NHS
Climate



Experience of rotational
doctors in training



Personal experience

WHY This Project

The Current NHS Climate

Gridlock as record number of ambulances queue at A&E in England
BBC 6/1/23

NHS Backlog: Who are the 7 Million?
BBC 9/12/22

NHS in crisis as 500 people die each week due to 'killer' to emergency care delays
The Mirror 1/1/23

WHY This Project

Context of doctors in training



2022 NTS (national training survey) revealed that 63% of trainees at moderate to high risk of burnout

The GMC has lost the profession's trust and respect

BMJ 2022 ; 377 doi: <https://doi.org/10.1136/bmj.o1374> (Published 01 June 2022)

Cite this as: BMJ 2022;377:o1374

Yearly rotation to different hospitals
&
Regular rotation to new departments

WHY This Project

Personal Context

- ▶ Involved in an SI during an earlier year of training
- ▶ Not involved in the process properly
- ▶ Sent an email pre-nights “DO NOT PANIC”
- ▶ Did not want other people to experience what I went through

WHAT I wanted to achieve

Aims

01

Demystify the process for serious incidents

02

Educate trainees on the importance of clinical governance and how to engage

03

Provide teaching on medical errors and disseminate learning from local learning points

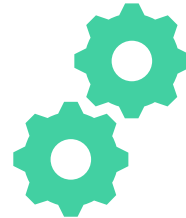
04

Ensure trainees know where to get support

WHAT I Did



Education



Improving
processes



Wellbeing

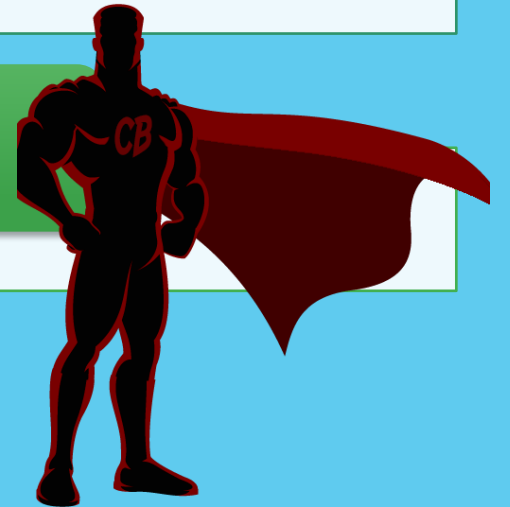
WHAT I did Education:

Lessons Learned: Lectures

Lessons Learned: Emails

Acute Medicine Morbidity &
Mortality Meeting

Lessons Learned: Clot
Busters



WHAT I did

Processes:

Re-developing the process of involving trainees in serious incidents changing:


- ▶ How they are informed, looking at wording of emails and process of informing staff
- ▶ Ensuring all staff involved are linked in with the local wellbeing service
- ▶ Ensuring educational supervisor / college tutors / program directors are informed when a trainee is involved
- ▶ Re-working the support and material provided to staff when involved in an incident (e.g. how to write a statement)

WHAT I did Wellbeing:



Connect

Link with the local junior doctor wellbeing service “Connect”

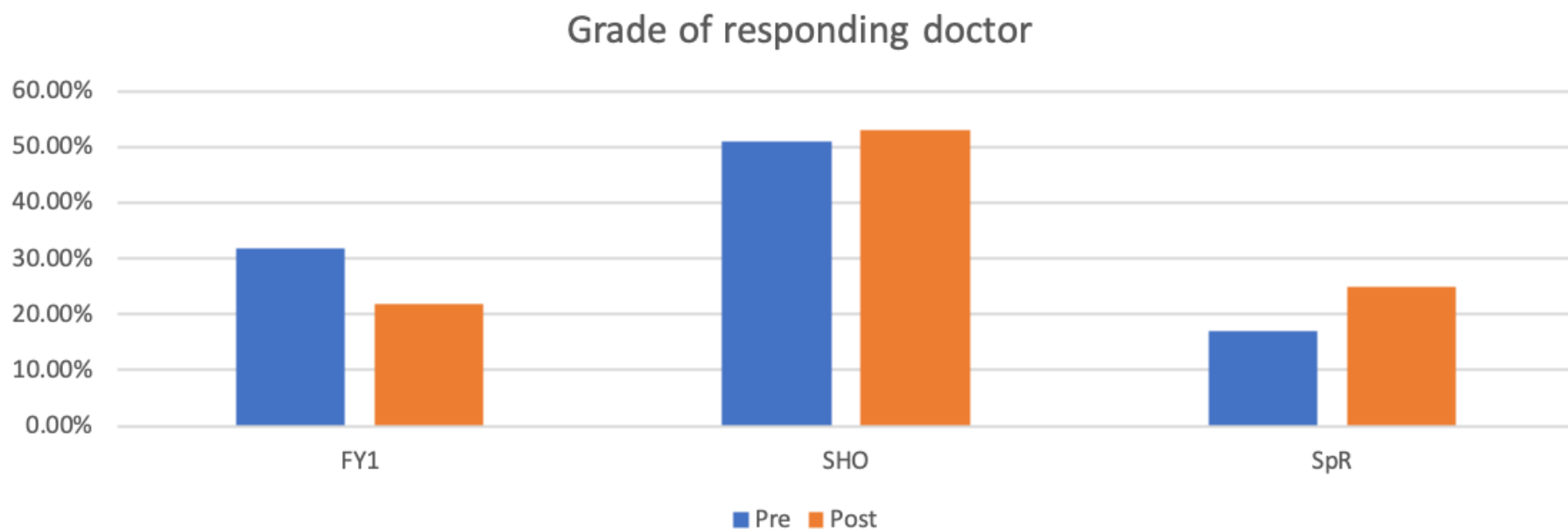


Ensuring staff across the hospital are aware of the service, know how to access support

WHY you should care

Results

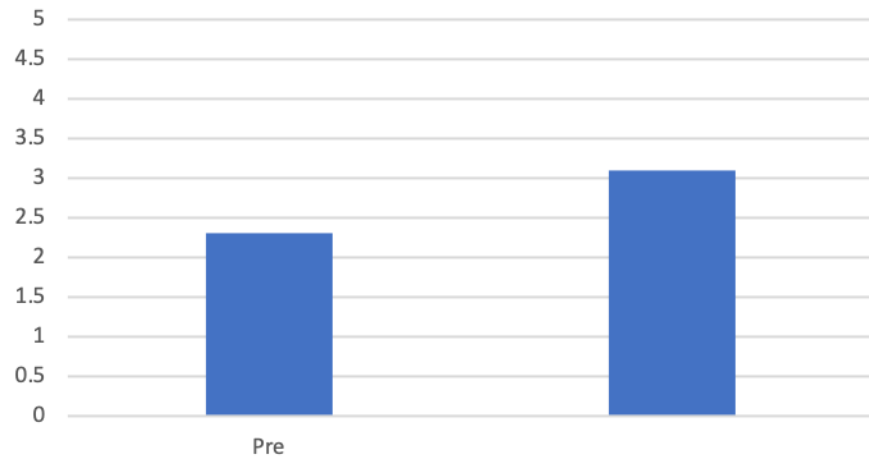
Initial survey - 47 staff
Repeat survey - 34 staff



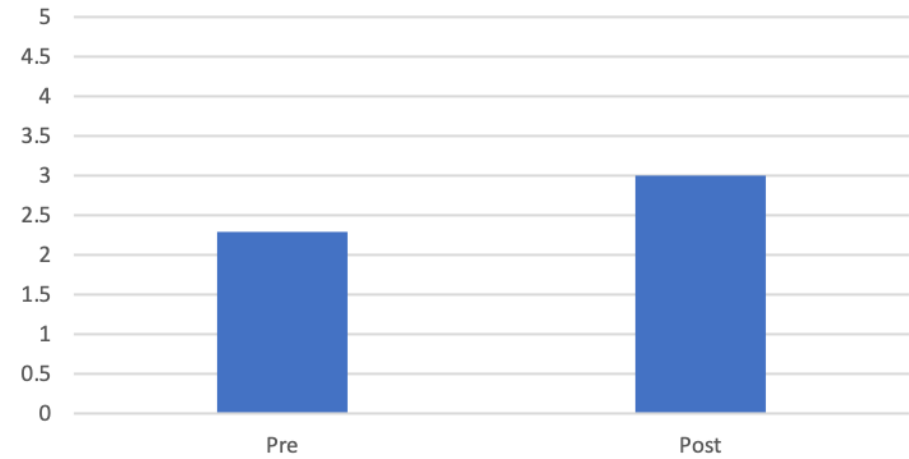
WHY you should care

Results

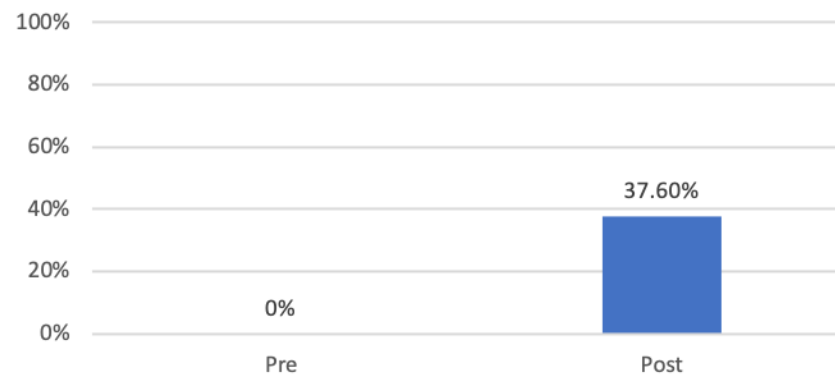
Well informed on Governance (1-5)



Well informed on SI Process (1-5)

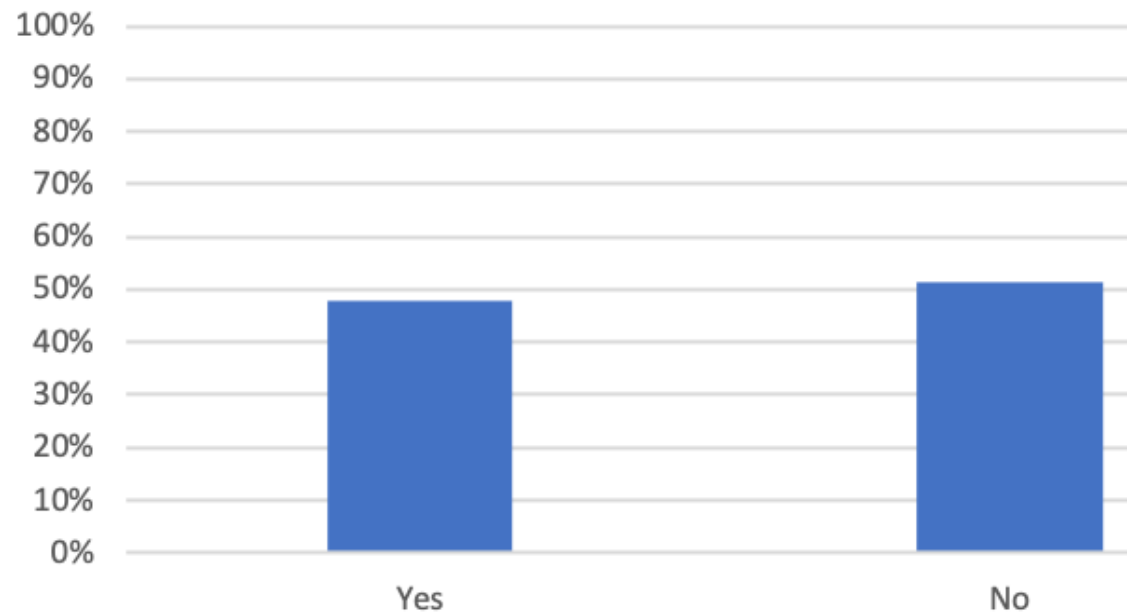


Frequency of relevant teaching (monthly or more)

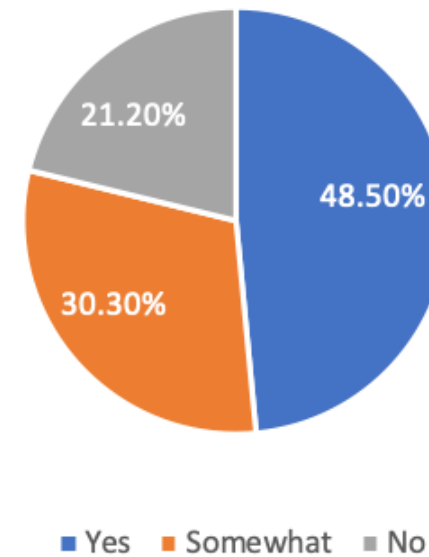


WHY you should care Results

Access to enough relevant teaching



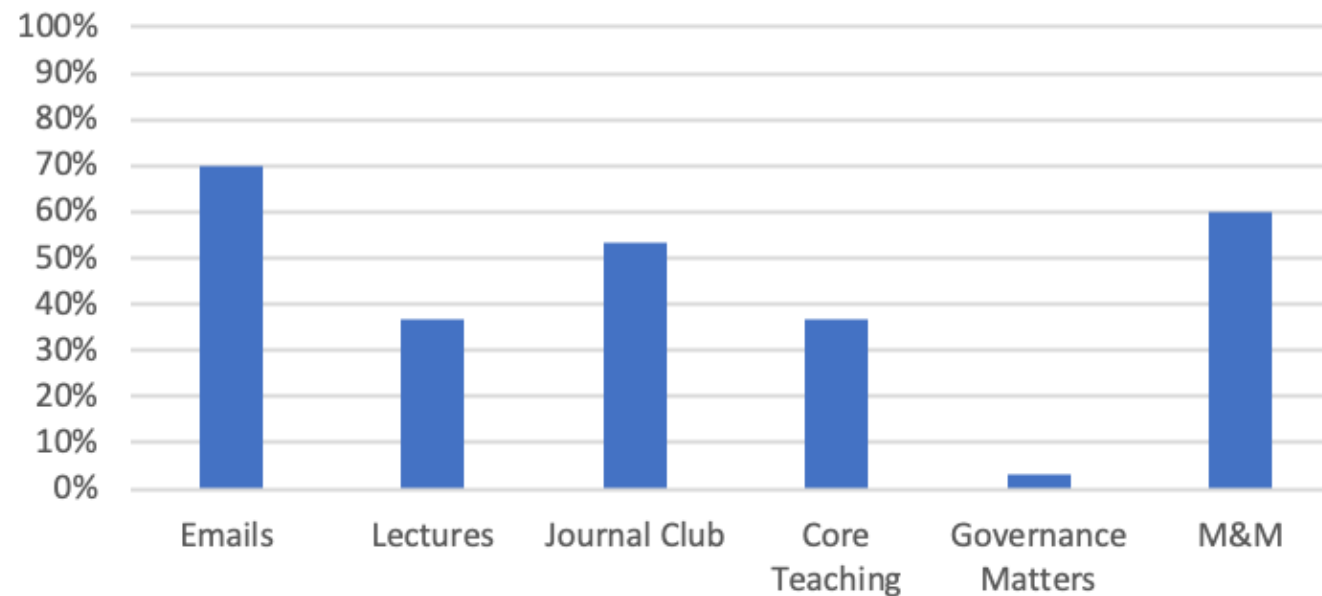
Teaching that has improved your understanding



WHY you should care

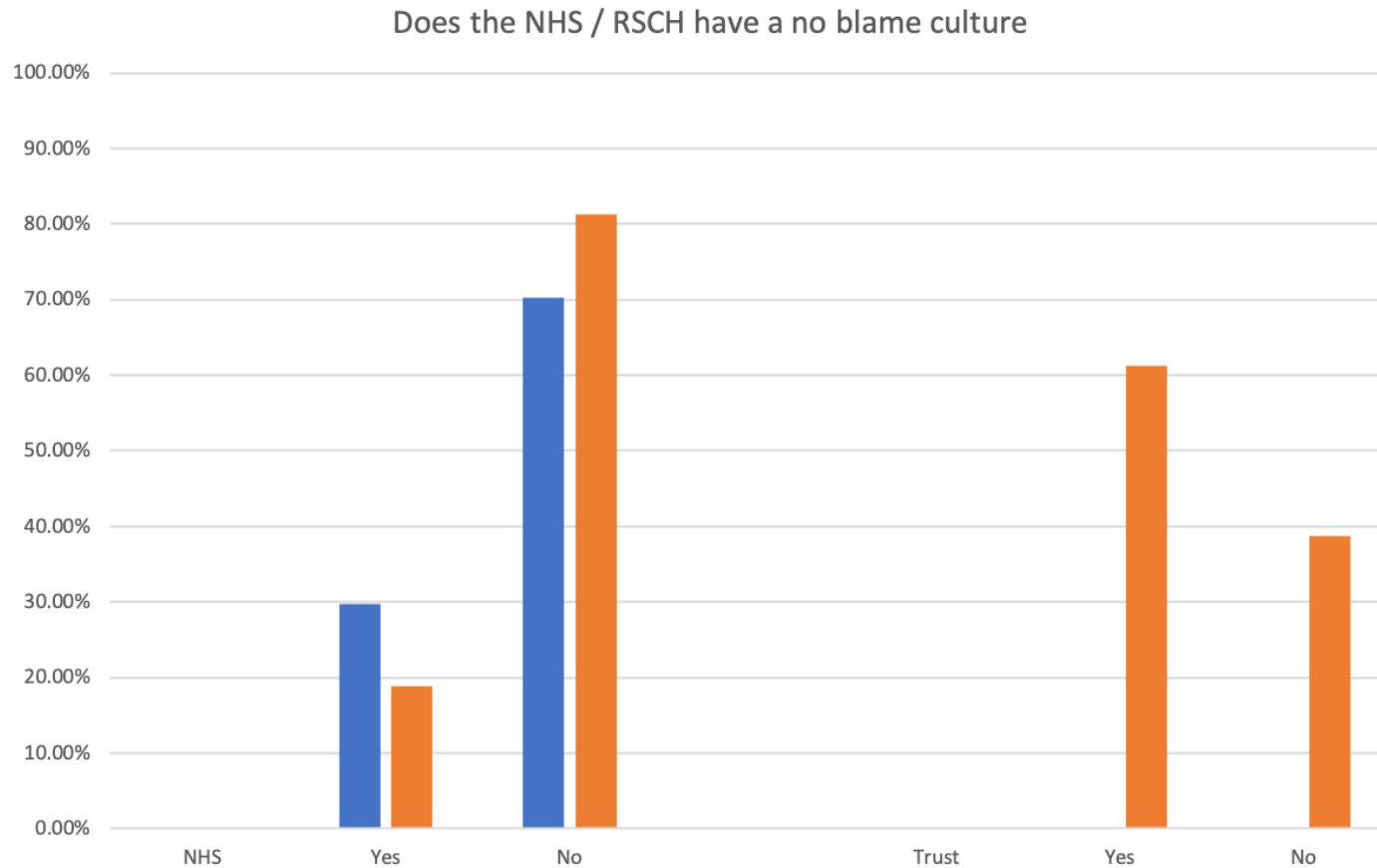
Results

Where have you been able to access relevant teaching



WHY you should care

Results



WHY you should care

Quotes

“Very relevant, gave me the confidence to speak up about an incident of 'us and them' I had experienced myself”

“I know lots of people get worried about getting something wrong (me included) and it's always nice to be reminded that making mistakes is normal as long as we learn from them and are honest!”

“It's an area I always struggle with and everyone else seems to know what they're doing. Maybe they don't after all!”

WHY you should care

Did I achieve my aims?

- 1. Demystify the process for serious incidents**
 - A little bit....
- 2. Educate staff on the importance of clinical governance and how to engage**
 - A little bit...
- 3. Provide teaching on medical errors and disseminate learning from local learning points**
 - A little bit...
- 4. Ensure staff know where to get support**
 - Yes! 20% rising to 80% knew where to get help (but not entirely down to me)

WHAT I learnt

Clinical Governance Matters to trainees

- ▶ There is a clear desire from trainees to learn about medical errors, governance and how to create a safe working environment
- ▶ We need to build this into our training programs
- ▶ We need to involve trainees in the processes of governance so they can have a true understanding & a meaningful contribution

WHAT I learnt

Trainees want to learn - Facilitate it!

- ▶ Learning has been badly affected by COVID-19
- ▶ We need to protect the learning opportunities within our hospitals
- ▶ We need to facilitate attendance from trainees
- ▶ We need to be creative in how we provide teaching in the post-covid NHS
- ▶ Lead from the top!

WHAT I learnt

Engage Trainees in your culture

- ▶ We arrive at your hospital not knowing what it is like
- ▶ Engage us in your culture early, let us know this is a safe place to work
- ▶ Ensure departments are directly addressing how to reach rotational doctors in a meaningful way

WHAT I learnt

We need to talk about medical errors!

- ▶ Medical errors matter - they are common and cause harm to both patients and staff
- ▶ With the NHS under more strain than ever we need to be coming together to support each other
- ▶ An honest and open culture around mistakes will create a safe working environment for patients and staff
- ▶ No blame and no shame

1

Work to engage rotational doctors in the culture of your hospital

2

Work to facilitate and enable trainees to access training

3

Build clinical governance training into your training program

4

Share and be open about our own errors and create an open, no-blame culture

Take home thoughts

**Thank you for
listening!**

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