MED+ 2023

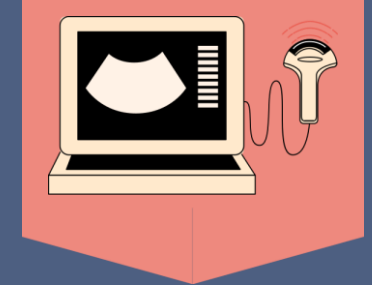# Education, training and medical professionalism posters

October 2023

Royal College of Physicians

SHOULD WE TEACH FOUNDATION YEAR 1 DOCTORS ULTRASOUND-GUIDED CANNULATION?

Ahmed Alhussni, Lewis Greenan-Barrett - Leeds Teaching Hospitals NHS Trust

INTRODUCTION

Ultrasound-guided cannulation is an increasingly useful skill, yet it is unclear whether newly trained doctors are proficient in its use. Our aim was to evaluate the confidence of Foundation Year 1 (FY1) doctors before and after an ultrasound-guided cannulation workshop.

METHODS & INTERVENTION

We surveyed 57 recently-graduated FY1 doctors in two UK NHS trusts on their cannulation and ultrasound-guided cannulation abilities.

We enrolled the same individuals in a 1 hour ultrasound-guided cannulation workshop run by FY2 doctors. The workshop consisted of a demonstration, practice session and an assessment. The group were then re-surveyed after the workshop.

KEY RESULTS

❖ Before the ultrasound workshop, recently-graduated FY1 doctors were unable to do an estimated 31% of cannulas and 89% had previously needed to escalate a cannula to a senior.

❖ 81% had never attempted ultrasound-guided cannulation and 100% wanted to learn how.

❖ Mean confidence in cannulation increased significantly from 46% before the course to 72% afterwards (p<0.001).

❖ 94% felt they will use ultrasound-guided cannulation as an FY1. 100% would recommend the course to other FY1 doctors starting their training.

CONCLUSIONS

Recently graduated doctors want to learn ultrasound-guided cannulation.

Most new doctors have no experience with ultrasound-guided cannulation.

A 1 hour workshop significantly increased confidence in cannulation.

Confidence in Cannulation

Lian A, Rippey JCR, Carr PJ. Teaching medical students ultrasound-guided vascular access - which learning method is best? The Journal of Vascular Access. 2017 Apr 20;18(3):255–8.
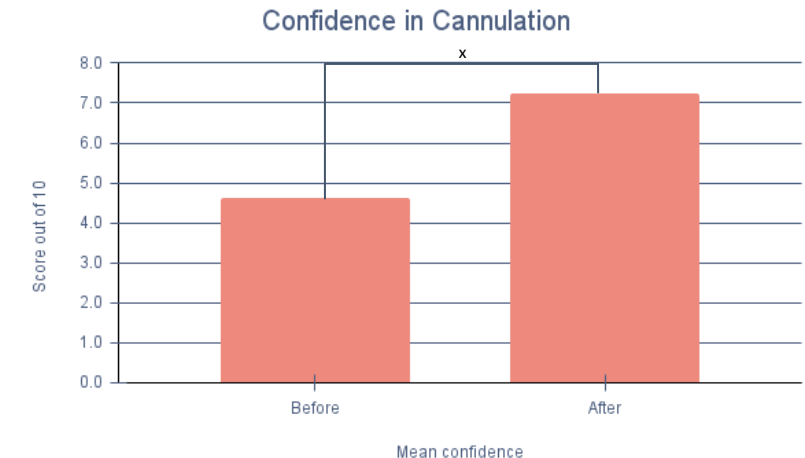
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Revising The Medical Night Handover Protocol – Improving The Clinical And Educational Merits Of Departmental Handover Processes

A. Hackney, E. Steer, F. Rees, M. Whitsey   New Cross Hospital, The Royal Wolverhampton NHS Trust

Topic: Education, training and medical professionalism

NHS The Royal Wolverhampton NHS Trust

INTRODUCTION

The general internal medical (GIM) handover is a critical juncture where preventable causes of patient harm can be addressed.[1,2] Variations between handover systems have been reported, with poor human factors and systemic errors being thought to arise in part from a lack of structured frameworks through which to practically guide handovers.[1-3]

In line with General Medical Council regulatory guidance, UK medical training programmes further outline clear recommendations regarding engagement with effective handover activities as a required component of professional development.[4-8] Whilst optimising handover processes may improve clinical safety, they may also therefore serve as

OBJECTIVES

We present the implementation of a re-structured, simultaneous acute medical take and ward GIM night handover protocol in a large West Midlands district general hospital, aiming to standardise and embed recommended clinical and educational principles into this important activity.

MATERIALS AND METHODS

PDSA methodology was utilised throughout. A novel proforma was devised to standardise the night GIM handover, in line with recommendations by the Royal College of Physicians (RCP) toolkit **(PLAN)**.[1] Handover was split into parallel acute take, (medical registrar-led) and ward ('Tier 2'– IMT1-2/senior clinical fellow-led) handovers; detailing a specific structure, time and location for handover, compared to previously where ward doctors would handover informally **(DO)**. A 3-day trial was undertaken (n=7), and following positive feedback a further 7-day trial was held (n=12) **(STUDY)**. A 03:00 huddle was introduced during the second trial, acting as a mid-shift 'check-in' and further opportunistic educational juncture. Feedback from on-call colleagues during trial periods guided further proforma iterations (Figure 1.) **(ACT)**. The second trial focused particularly on surveying the perceived educational benefit of medical handovers.

Figure 1. GIM night handover proforma – Post-cycle 1 iteration

RESULTS AND DISCUSSION

Standardised clinical handover should...

1) Be imbedded in hospital policy and culture

Ward cover doctors:
- "Proper handover of individual wards to night duties".
- "Ward handover was more formal and everyone had the opportunity to know about unwell patients".

2) Involve training in handover and communication

Ward cover doctors:
- "Good practice for future handovers, including how long day doctors handover (SBAR)".

Medical registrars:
- "Organised, well led. Confidence and experience gained by the Tier 2 was well appreciated and positive [to develop] leadership skills".
- "I like the new format, although it puts more responsibility on Tier 2, I would argue this was beneficial for their training".

3) Command designated time and location

Ward cover doctors:
- "Good to have a quiet space. Dedicated space for this was good".
- [What changes would you like in the night handover procedure?] "Dedicated room for ward handover".

4) Determine clear arrangements for ongoing care of patients

Ward cover doctors:
- "Useful for senior doctor to delegate urgency of jobs list".
- "Useful for Tier 2 to provide feedback regarding patient management".

Consultant:
- "I felt assured that the ward doctors had reported to a senior doctor who could assess if there was a need to escalate any issues".

Figure 2. Sample of Cycle 2 qualitative data responses, collated and mapped

Initial feedback themes directed protocol design towards safety, efficiency and developing clinical/leadership training opportunities. 75% of respondents strongly-/agreed innovations were an improvement, providing formal structure and early identification of unwell patients. 75% of trainees strongly-/agreed that handover was an educational experience post-innovation, improving from 58.3% previously. Supervised handover leadership and workload prioritisation opportunities were particularly valued (Figure 2.).

As colleagues from numerous healthcare practices are in attendance, handovers provided interdisciplinary learning opportunities, where those at earlier training stages could observe role models coordinating effective practice. This is particularly important in the local context of our hospital's medical on-call team structure, 'Tier 1' ward cover doctors comprising of junior clinical fellows, foundation and GP trainees. A sample of the qualitative data collected was mapped onto the themes of the RCP

CONCLUSIONS

Although scarce, reports of formally implemented improvements targeting medical handover processes have evidenced positive outcomes.[8-9] Our local handover developments were well received, emphasising a sustainable, standardised and educational approach.

Following local GIM steering group review, our protocol has been permanently implemented into the night handover standard operating procedure. Suggested improvements have prompted plans to introduce ongoing educational forums focused on developing effective and educational handover leadership styles.

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9.

MEDWRK: A SOLUTION TO MEDICAL NETWORKING

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- New Cross Hospital, Royal Wolverhampton Trust, Wolverhampton
- Walsall Manor Hospital, Walsall Healthcare NHS Trust, Walsall
- University of Cambridge School of Medicine, Cambridge

SIGN UP TO OUR TESTING NOW!

INTRODUCTION

Medical networking in the UK faces challenges that hinder effective collaboration and access to opportunities, particularly as competition for specialty posts intensifies. Current and prospective healthcare professionals must build strong portfolios to enter and progress in training.

AIM

This study examines the views of current and prospective healthcare professionals about medical networking and the potential benefits of a specialised medical networking application.

WHAT IS MEDWRK

MedWrk is an initiative begun by a diverse range of healthcare professionals aiming to create the medical network that has been absent for us all.

METHODOLOGY

A survey was conducted using Google Forms to gather feedback on a proposed medical networking application. distributed amongst a range of healthcare professionals.

It consisted of binary questions for quantitative data on participants' current satisfaction with medical networking and their perceptions of existing challenges in obtaining networking opportunities, as well as free text boxes for additional explanation, including their outlook on the future of medical networking.

RESULTS

86 out of 100 students completed the survey (response rate = 86%). Our key findings:

- **61.4%** believe there is a lack of opportunities for medical networking.
- **77.1%** cite difficulties in finding research, audits and presentations.
- **86.7%** are unaware of a social network application for healthcare professionals.
- **77.1%** are willing to test an application exclusive to healthcare professionals.

WHAT ARE THE AIMS OF MEDWRK?

We strive to provide an application and platform for healthcare professionals to find and promote their research, audits, and work experience. For open access to all, users can seek opportunities within and beyond medicine. The three key aims we have are
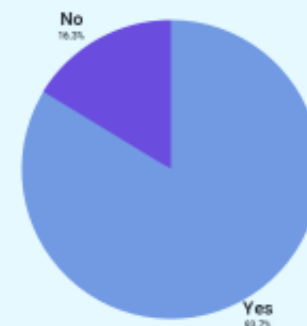
Help in finding opportunities

Improving outreach of research, audits, conferences and work experience

Overcoming networking barriers for all levels of medical professionals

""A social network for healthcare professionals would be beneficial to enhance networking for opportunities"

No
16.3%

Yes
83.7%

CONCLUSION

These results underscore the shortcomings of the current state of medical networking in the UK. Many participants encounter difficulties accessing networking opportunities and resources, emphasising the need for a comprehensive medical networking application.
Addressing these challenges through a dedicated platform could foster collaboration, knowledge-sharing, and exploration of diverse opportunities, both within and beyond the medical space, and in turn, advance patient care.

Non-Invasive Ventilation (NIV) training – the Kent, Surrey and Sussex (KSS) experience: Still just optional in the post-COVID curriculum?

Background

Acute NIV is the standard of care for acute hypercapnic respiratory failure secondary to COPD1). However, across England, junior doctors training in NIV is generally variable and not mandatory, despite the fact that it is junior doctors who inevitably look after these patients and responsible for crucial clinical decision, especially out of hours.

Objectives

1) To benchmark current training provision in NIV for IMTs
2) To evaluate the NIV training provided by KSS deanery

Method

From 2014 to date, HEKSS has mandated NIV training workshops for all IMTs. These comprise of presentations, case scenarios and hands-on experience and both qualitative and quantitative feedback/data is collated following every workshop.

A survey via mobile conversations, texts and social media communication was also carried out to ascertain NIV training arrangements across England and Wales.

The satisfaction scores of the course attendees regarding the individual stations were attained by using CSAT, Customer satisfaction score calculation equation as below.

$$CSAT = \frac{\text{Total number of satisfied customers}}{\text{Total number of responses}} \times 100$$

Only KSS and Thames Valley deaneries provide regional NIV training with Respiratory physicians as presenters/trainers (Fig 1.Deanery NIV Training England & Wales)
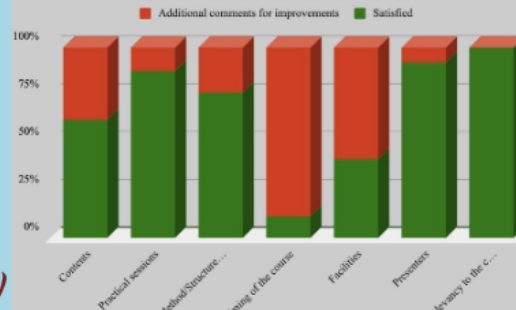
The established KSS RTD

A regional training day with a comprehensive agenda focused on both theory and practical sessions for Non-invasive ventilation and pleural procedures for Internal Medicine Trainees training across Kent Surrey Sussex has been established and mandated since 2014 by KSS training programme directors. The course is led by a Respiratory Physician and facilitated by practising Respiratory clinicians. The course has trained 762 IMTs at 29 courses organised over ten year period.

RESULTS

At 23 out of 29 courses, the attendees' satisfaction scores of Initiation, monitoring and weaning NIV session was 100 %.

Qualitative feedback

Authors: Dr Burhan Khan, Dr Thaw Thu
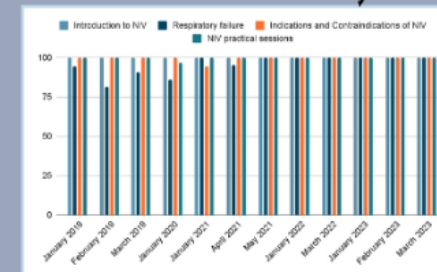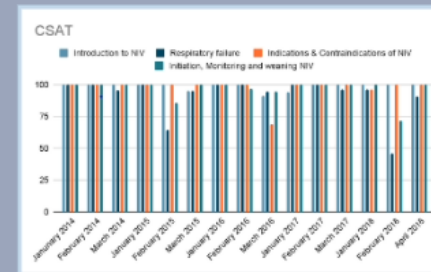
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Are Junior Doctors In The UK Stressed Out During Their On-call Shifts?

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Sheffield Teaching Hospitals
NHS Foundation Trust

Background

On-call duties have been rated to be among the most stressful aspects of physicians' work. On-call work has been associated, for example, with medical errors, injuries and lower well-being. Thus, because it is not possible to remove on-call duties, measures to decrease the negative ramifications of on-call work are needed [1]. Doctors across hospitals and general practice who are experiencing burnout are twice as likely to be involved in a patient safety incident and three times as likely to leave their job, according to a new research paper that included 239,246 doctors from across America, Europe and the UK.[2]

Objectives

To highlight the factors causing stress among junior doctors during their on-call shifts.

Subsequently, taking steps to address these factors and escalating them to the management level for implementing changes that enhance working conditions, thereby improving efficiency in patient care.
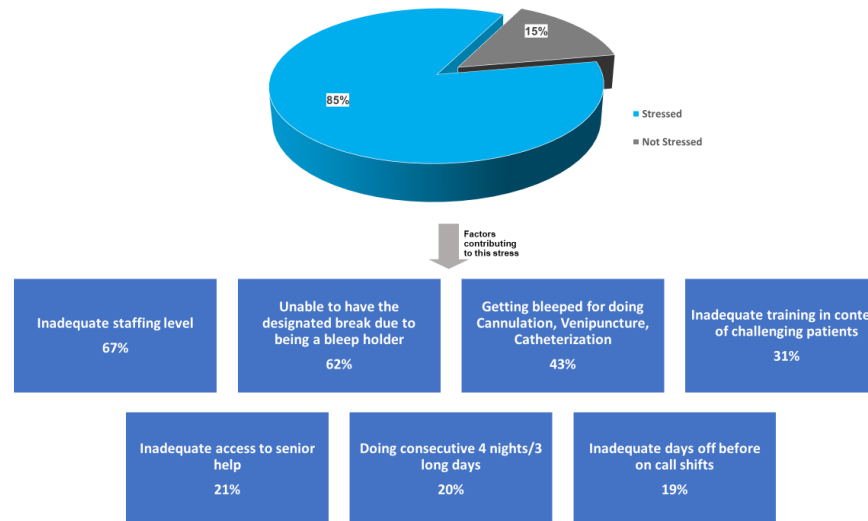
Methodology

In view of the above, a cross-sectional cohort study was carried out at Queen Alexandra Hospital in Portsmouth. This study focused on junior doctors representing 24 different departments, with the aim of investigating the presence of stress during their on-call shifts and identifying potential contributing factors. The study employed a semi-open questionnaire as part of its methodology. A total of 117 doctors have participated.

Grade Of Doctors

9%
28%
27%
15%
22%

- FY1
- FY2
- ST1
- ST2
- ST3 or above
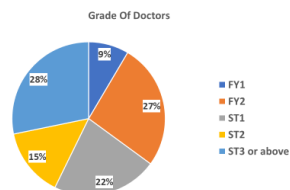
Results

The study's findings indicate that stress is prevalent during on-call shifts, with 85% of doctors reporting its presence. In the context of the healthcare workplace our survey has identified several key factors contributing to this issue.

15%
85%

- Stressed
- Not Stressed

Factors contributing to this stress

| Inadequate staffing level 67% | Unable to have the designated break due to being a bleep holder 62% | Getting bleeped for doing Cannulation, Venipuncture, Catheterization 43% | Inadequate training in context of challenging patients 31% |

| Inadequate access to senior help 21% | Doing consecutive 4 nights/3 long days 20% | Inadequate days off before on call shifts 19% |

When asked which patients they found most challenging, respondents highlighted mental health crises as the top difficulty. Following closely, acutely deteriorating patients were also mentioned as particularly challenging. Moreover, healthcare professionals expressed challenges in dealing with acutely confused patients, cases of cardiac arrest, and patients experiencing alcohol intoxication.

Interestingly, the study also revealed a noteworthy demographic distribution among respondents, with 53% comprising international medical graduates (IMGs) and 47% representing UK medical graduates. What added to the intrigue was the discovery that 57% of the participants indicated this wasn't their first NHS position. Surprisingly, despite having more than six months of NHS experience, these doctors continued to experience significant stress levels. An equally surprising revelation was that a substantial portion of the respondents had embarked on independent on-call duties within less than a month of commencing their posts. This juxtaposition of prior NHS exposure and the rapid initiation of independent on-call responsibilities raises compelling questions about the dynamics of stress in this professional context.

Discussion & Conclusion

In conclusion, this study sheds light on the prevalent issue of stress among junior doctors during on-call shifts. Notably, our findings highlight that stress affects a significant majority of doctors, regardless of whether they are international or UK medical graduates. The surprising aspect lies in the fact that a substantial number of doctors had prior NHS experience, yet the stress persisted.

These insights underscore the critical need for addressing stress among junior doctors, recognizing its direct impact on both their well-being and the quality of patient care they provide. Collaborative efforts between the rota team, recruitment team, and HR are paramount to ensure adequate staffing levels and address rota gaps, ultimately enhancing patient care.

Moreover, incorporating medical technicians for procedural support, particularly in tasks like cannulation and venipuncture, can significantly alleviate the time constraints on junior doctors, allowing them to focus on more complex medical responsibilities.

Enhancing the trust induction program by incorporating simulation training on managing acutely deteriorating patients, understanding the Mental Health Capacity Act and navigating mental health crises, familiarizing with trust protocols and guidelines presents an opportunity to maximize the efficacy of the staffs. These proactive measures will not only contribute to junior doctors' well-being but also promote the overall efficiency and quality of healthcare services.

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Exploring the experiences of Widening Participation (WP) and non-WP students in medical school:
A Qualitative Study

Dr Christy Varghese (IMT 2), Dr Kelsey Inouye (Supervisor)

UNIVERSITY OF OXFORD

Background and Theoretical Framework

Widening participation is the active process of ensuring that the higher education cohort within the UK is representative of the general population (Connell-Smith and Hubble, 2018)

There are significant improvements happening in terms of widening access to medicine. The proportion of WP students progressing to higher education increased to 80%

'Permeable habitus' is the theoretical framework used in this study built on the work of Pierre Bourdieu (Reay et al, 2009). Habitus is described as a set of internal dispositions that encompass both the external social structures and the history of the individual

Bourdieu theorised habitus prevents individuals from being part of 'another' world. 'Permeable habitus' states that individuals can learn to adapt to new environments and social classes

Methods

Participant sampling

7 Universities from England, Scotland and Wales were included in the study

34 Participants: 20 WP and 14 non-WP

Recruited through social media, emails, university notifications

Data collection

Online qualitative surveys

15 open-ended questions were used

The questions were all developed using the literature review

Data analysis

Thematic analysis carried out using NVivo 12 and was based on Braun and Clarke (2006)

Used a combination of inductive and deductive analysis

10 pre-existing themes and 2 themes emerged

Conclusion

Widening Participation (WP) students face discrimination before and during medical school.

WP students constantly compare themselves to their peers and have feelings of not fitting in.

Costs involving resources, extra-curricular activities and social life are a significant barrier for WP students.

All students generally become more confident, mature and organised after joining medical school.

Discrimination based on race happens regarding both WP and non-WP students.

Non-WP students realise their privilege for the first time in medical school.

Results

1. Applying to medical school — "My school actively discouraged me from applying to medicine, stating I wouldn't fit in"

2. Comparisons and not fitting in — "I often get imposter syndrome and feel like I am not smart enough to be here"

3. Effects of the curriculum — "It does still feel like most of it is based on the 'average white man'"

4. Effect of background — "their parents are doctors also, so they seem to have a better understanding"

5. Opinions on diversity — "Doctors should represent the population they serve"

6. Individual changes — "I think I've become more confident over my time at university"

7. Discrimination in medical school — "I've had multiple consultants ask which school I went to and whether my parents are doctors"

8. Social life in medical school — "I started spending more quality time with people who I wanted to spend time with".

9. Quitting medicine — "My family and I had been through a lot and sacrificed too much for me to drop out"

10. Costs in medical school — "financial hardships have also made me feel out of place"

11. Realisation of priviliege — "I didn't realise how fortunate I was financially growing up before coming to university"

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Using A Simulated Outpatient Clinic To Improve Trainees Confidence And Performance

Colette Davidson, Emma Lewin, Jessica Little, Paula Lee, Stephen Hamshere - Education Academy, Barts Health NHS Trust

Background

Most secondary care patient interactions occur in outpatient clinics,[1] yet junior clinicians perceive many barriers to learning in OP setting.[2]
We propose using simulation to educate clinicians on outpatient encounters before regular practice, enhancing their skills and confidence in delivering effective care.

Aims

Increase junior clinicians' confidence during OP clinics

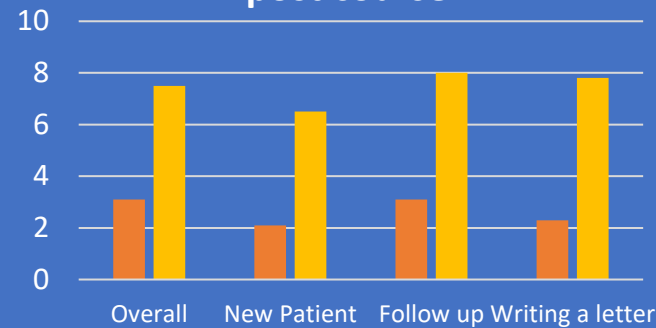Conduct a new patient and follow up appointment

Write a clear and coherent letter

Course plan

- New Patient
- Follow up
- Crisis manage
- Clinic admin
- Write a letter

15 min stations

Assessed according to agreed expected actions

Followed by a group debrief focusing on technical skills and human factors

Quantitative data

Attendees	FY1	3	FY2	4	IMT	1

Self rated confidence pre and post course

100% attendees would recommend this to colleagues

Qualitative data

What skill have you developed?
Prioritising issues
Managing workload
Confidence speaking to patient

What else would be helpful?
Presenting to a consultant
Dealing wit frustrated/angry patient
Surgical scenarios
Telephone clinic

Conclusions

Doctors have poor confidence about OP work

Confidence is improved by simulated practice

Doctors find this helpful and would recommend it

Future plans

Run follow-up sessions to demonstrate that simulated OP clinic improve performance

Offer this teaching session to all FY2 doctors in the trust

Incorporate conducting remote appointment and discharging patient into future courses

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Barts Health Simulation
Newham - The Royal London - Whipps Cross

Clues And Codes: The Use Of Escape Room Simulation To Teach Medical Students How To Manage The Acutely Unwell Patient

Emma Lewin, Jessica Little, Colette Davidson
Barts Health Simulation Department

Background and Aims

It is widely recognised that a key skill required for junior doctors is the management of acutely unwell patients as they may have this responsibility from their first day. For patient safety reasons, it is rare for students to experientially learn these skills on their clinical placement and, consequently, students reported feeling nervous and insufficiently prepared to manage these scenarios. Therefore, we sought to develop a novel method for teaching students how to safely and systematically manage these, potentially unexpected, situations.

As gamification becomes more popular in medical education, the use of medical escape rooms is increasing. During these sessions, participants are 'locked' in a room and are required to solve a series of puzzles related to a medical scenario in order to 'escape'. A relatively novel educational method, further evidence is required to demonstrate its efficacy and potential applications in undergraduate teaching. This project aims to evaluate whether escape room simulation can be used to help third year (first clinical year) medical students develop their assessment of an acutely unwell patient and consolidate clinical knowledge from tutorials.

Methods

- A scenario, in which students were called to assess a patient with new breathlessness and confusion, was developed and integrated into the Year 3 teaching timetable at St Barts Hospital

- During the simulated on-call scenario, students encountered barriers in the form of locked boxes and clues during their management. The aim was to recognise sepsis and safely treat and refer the patient before 'escaping'

- Students complete pre- and post-session feedback questionnaires with a mixture of qualitative and quantitative questions

- A debrief discussion took place following completion of the scenario

- Feedback was evaluated and used for quality improvement

Results – Pre- and Post-Session Comparisons

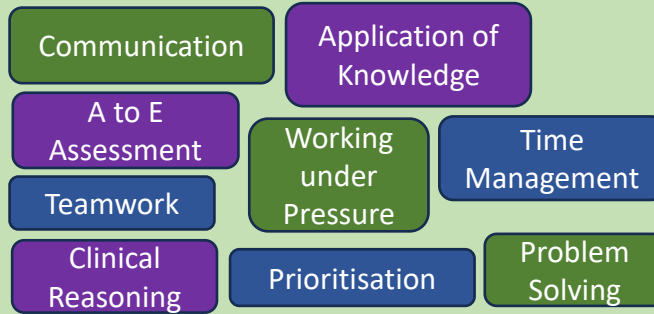In total, 45 students participated in the escape room simulation

Self-rated Confidence levels	Average pre-session (/10)	Average post-session (/10)	Average Change
A to E Assessment	6.5	8.2	+1.7 ⭐
Sepsis Management	6.4	8.1	+1.7 ⭐

On average, the escape room was rated highly for **enjoyability (9.53/10)** and **educational value (9.51/10)**

⭐ = Statistically significant result (Paired t-Test)

Results- Qualitative- Skills Developed

Communication

Application of Knowledge

A to E Assessment

Working under Pressure

Time Management

Teamwork

Clinical Reasoning

Prioritisation

Problem Solving

Results –Qualitative- Themes: Pros and Cons

Pros	Cons
Encourages Teamwork	Game distraction
Structured Assessment	Unrealistic lack of flexibility
Develops Problem Solving Skills	Can lose patient focus
Working under pressure	Simulation artefact
Consolidation of knowledge	Reliant on team dynamic
Practise Communication	
Fun and engaging	

Conclusion and Next Steps

- Students had an overwhelmingly positive response to the escape room and requested additional sessions
- Evaluation suggested that participants valued applying their A to E assessment and revising sepsis management in an enjoyable setting, which they felt stimulated easier recall of these key concepts
- Evaluation suggests that it can be used to consolidate clinical knowledge and simulate a pressured environment, not dissimilar to clinical practice, while practising technical and non-technical skills required in emergency scenarios
- Further research is required into the longevity of this effectiveness and the long-term outcomes
- Next steps for this project include objective evaluation of knowledge using SBA questions before and after the escape room and the development of new clinical scenarios using the escape room format

RaMH: Proposing a Curriculum Framework for Refugee and Migrant Health for UK Medical Students

Authors: Warrens Hilary [1], Jeyapala Jeyapragash [2], Blakeway Helena [1], Craig Amy [1], Tol Isabel [1]
Affiliations: St George's University Hospitals NHS Foundation Trust [1], Imperial College Healthcare NHS Trust [2]

Introduction:

➢ Refugee and migrant health (**RaMH**) needs are complex.

➢ The UK offered protection to **175,142** people between June 2022 and June 2023, and this population is growing. [1]

➢ However, UK medical training does not equip graduates with the knowledge and skills required to confidently care for this vulnerable population. [2]

Materials and Methods:

A PubMed Literature review identified papers related to RaMH education.

↓

Papers were critically appraised by a panel of five UK-trained NHS doctors with experience in Medical Education.

↓

Literature findings and educational theory informed curriculum development.

↓

Learning objectives were mapped to the General Medical Council's (GMC) outcomes for medical school graduates. [3]

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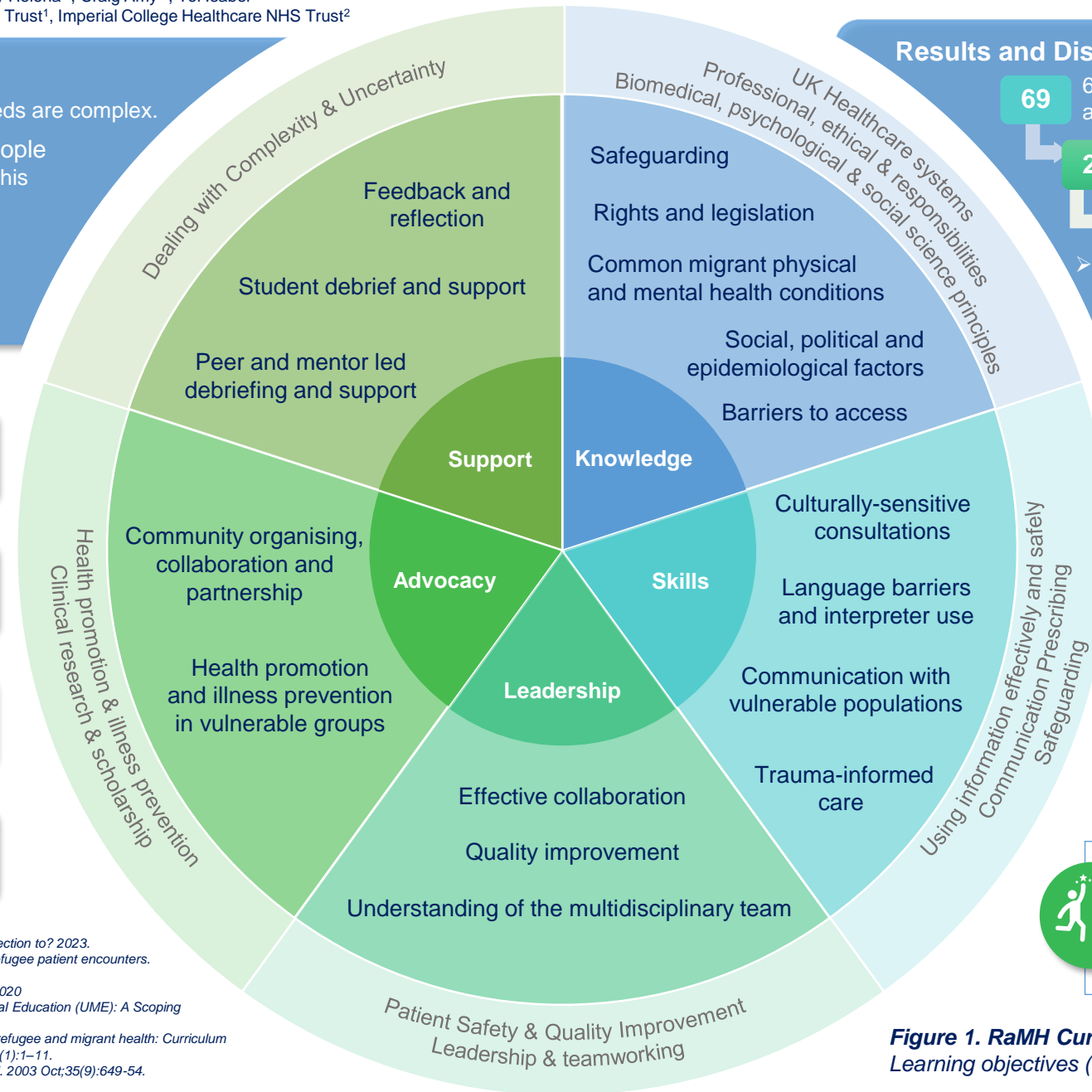
Results and Discussion:

69 67 publications were identified by Pubmed search, and a further 2 papers by citation searching.

24 publications met inclusion criteria.

3 publications were UK-based.

➢ Learning objectives were formulated from recurrent topics and grouped into 5 core themes.
  ➢ Learning objectives aligned with GMC outcomes for graduates (Figure 1).
  ➢ Teaching modalities were also considered for onward curriculum implementation.

Conclusions:

The increasing need for RaMH competency is not reflected in the UK Medical Education literature or medical school curricula. [2,4]

The RaMH Curriculum address this and has scope to cover all current GMC Outcomes for Graduates.

Experiential learning initiatives with refugees and migrants have high student and service user satisfaction. However, structured student support mechanisms must be in place. [5,6]

Figure 1. RaMH Curriculum Framework. *Core Themes (inner ring); Learning objectives (middle ring); GMC outcome-mapping (outer ring).* [2,4-6]

Generalism in Internal Medicine Training:
Nurturing Holistic Clinicians

Khin Yadanar Kyaw[1], Zuleikha Mistry[2], Sacha Dowling[2], Kandace Baggan[1], Nebras Hasan[1]

University Hospitals of Derby and Burton NHS Foundation Trust[1], Chesterfield Royal Hospital NHS Foundation Trust[2]

NHS England

Background

The UK's ageing population with complex multi-morbidities is well documented.[1] NHS England commissioned the innovation of a pilot programme - 'Enhancing Generalist Skills' - incorporated within Internal Medicine Training (IMT) in response to their Future Doctor's report[2]. The East Midlands was a trailblazer site, with 5 IMT doctors from Royal Derby Hospital and Chesterfield Royal Hospital started in August 2022. **Figure 1** demonstrates the programme's core themes.

Community Placements

The Enhance trainees undertook a novel 4-month 'Leadership and Social Medicine' rotation in the community, whilst still taking part in the on-call rota in our respective acute hospitals. **Figure 2** displays the different elements which made up our four-month rotation. We were embedded in some of these services after a period of shadowing, allowing us to partake in decision making and having an impact on patient care in the community. Shared learning took place from all parties.

Community Hospital
Acute Home Visiting Services
Mortality Review Group
Dementia Palliative Care Team
Nursing/Residential Home Ward Round
Frailty Team Community Physiotherapy
Diabetes Education Service
Rehabilitation Ward
Sexual Health Clinic

Figure 2: Word Cloud demonstrating community activities

Teaching Opportunities

Teaching sessions were centred around population health, informing social policy and human factors. These have encouraged us to identify and address health inequalities in our day-to-day practice, whilst teaching on stress and trauma sciences has increased our awareness of how some of our patients' own experiences can affect their own health choices and subsequently the healthcare services available to them.

Immersive Placements

Through immersive placements, we continue to collaborate with organisations providing care to vulnerable communities on quality improvement projects. We have been working with Changing Future Nottingham, Inclusion Health and Nottinghamshire Sexual Violence Service. **Figure 3** demonstrates how these organisations work for vulnerable communities. We work with these teams to review care pathways and train professionals on dealing with complex health issues faced by vulnerable communities.

Changing Futures Nottingham	Improving the lives of people facing SMDs (Severe Multiple Disadvantages)
Inclusion Health Leicester	Service provided to the marginalized population who have complex or unmet needs
Nottinghamshire Sexual Violence Service	Where they provide specialist support for survivors of sexual violences

Figure 3: Services that we collaborate during immersive placements

Leadership Opportunities

As the premier cohort, we participated in leadership opportunities at regional workshops and conferences with stakeholders and interested parties to co-create the future curriculum. After our first year of Enhance program, we are now well-equipped to provide peer-mentoring for new Enhance trainees. This involves offering guidance to overcome the challenges alongside sharing our own experiences. We also continue to work with our respective immersive placement organizations to have a meaningful impact on the surrounding communities.
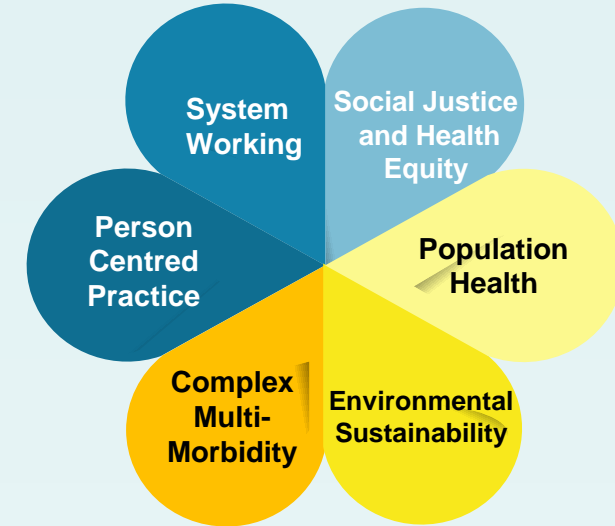
System Working
Social Justice and Health Equity
Person Centred Practice
Population Health
Complex Multi-Morbidity
Environmental Sustainability

Figure 1: Demonstrating core themes of Enhance program

Reflection

From this programme, we were able to appreciate holistic approach in treating patients. This has enabled heightened awareness on the social determinants of health and the capabilities and limitations of the community services. This curriculum has facilitated streamlined communication between primary and secondary care which is beneficial to both patients and healthcare providers.

We believe that this is a great innovation to the Internal Medicine Training (IMT) program, we have gained Generalist skills alongside achieving progress and competencies as other IMT trainees. Due to the success of our first year of the Enhance program, it is now expanding to reach different levels of medicine trainees including medical students, foundation years and advanced clinical practitioners.

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Simulation-based training as a tool for developing non-technical skills for future Medical Registrars

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Royal College of Physicians

NHS Sandwell and West Birmingham Hospitals NHS Trust

Topic: Education, Training and Medical Professionalism

Introduction

The transition into the medical registrar role continues to be perceived as a challenging and stressful period of Internal Medical Training (IMT). Trainees often work in high pressure environments, managing acutely unwell patients whilst also coordinating other, often non-clinical, management issues.[1-2] Historically, medical trainees have voiced that they felt inadequately equipped with the experience and skills to step up to the registrar role.[3]

There is a growing appreciation of the role of non-technical skills underpinning a large part of this responsibility, however, formal purposeful reflection on these aspects of practice can be difficult due to their nature and timing.[2,4] High fidelity simulation-based education is a prevailing modality through which these skills can be explored and reflected on.[5]

Objective

Design and locally implement a novel simulation for IMT2 trainees at a West Midlands Trust, developed to explore and learn from non-technical and human factors aspects of the medical registrar role.
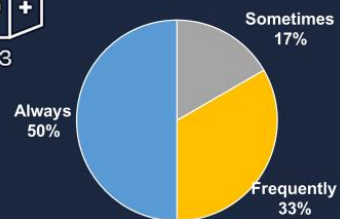
Material/Methods

IMT Stage 1 Clinical + Generic CIPS[4]

Trust Serious incidents

High Fidelity Sim Suite

Paired Trainees

Simulation Scenario

Remote observation

Group Debrief

Medical + Sim Faculty
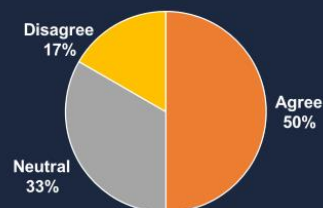
Non-Technical Skills Focus

Figure 1: Structure of simulation session

➡ Half Day Pilot with Six IMT2 Candidates
➡ 3 Sim scenarios modelled on trust serious incidents
➡ Outcome mapping to IMT Stage 1 Curriculum [4]
➡ Paired trainees undertook 15 min Sim
➡ Group debrief for 30 min led by senior medical (ST5+) & experienced sim faculty
➡ Anonymous pre & post-course qualitative data collected via online form

Results

Reported trainee anxiety and preparedness towards the medical registrar were echoed in our pre-course survey responses (N=6) (Figure 2., 3.). All trainees agreed that simulation scenarios gave a realistic representation of clinical practice and that debriefing facilitated exploration of non-technical learning outcomes. Pre- and post-course questionnaire self-reported trainee confidence to take on the medical registrar role improved across both clinical and non-clinical aspects (Figure 4.).

Discussion

100% of trainees either agreed or strongly agreed that further simulation would help improve preparedness for the medical registrar role and that non-technical skills-focused simulation should be a mandatory part of the IMT Stage 1 curriculum. Notably, no trainee felt that they had received sufficient feedback on these skills in their day-to-day practice. Though the IMT Stage 1 curriculum recognizes the importance of developing these skills it does not require human factors simulation until IMT Stage 2.[4]

Conclusions

Non-technical skills are a vital part of a medical registrar's role. Our pilot session demonstrates that trainees value the opportunity to explore non-technical focused simulation training in a safe, confidential setting. Real-time feedback from senior physicians was felt particularly helpful to evidence non-clinical capabilities in practice. We would recommend that similar initiatives are introduced earlier in IMT Stage 1.

MED + 2023

Sometimes 17% **Always 50%** **Frequently 33%**

Figure 2.
Are you ever anxious thinking about being a medical registrar?
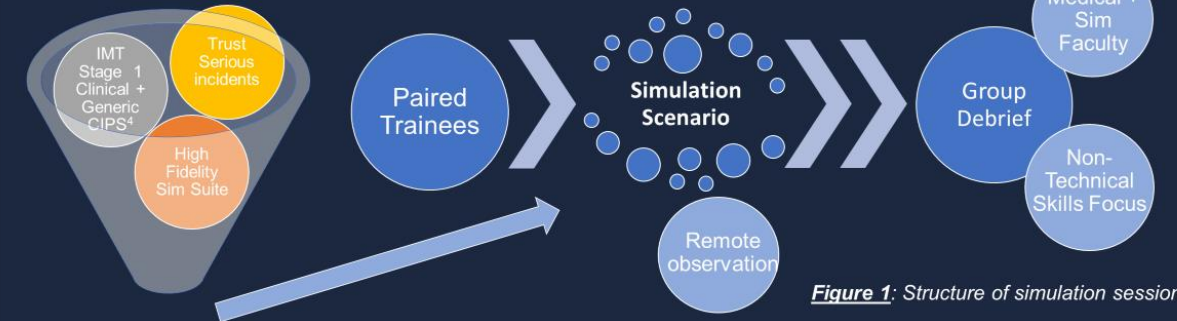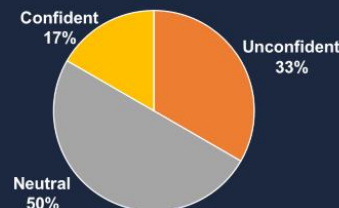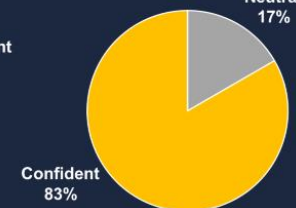
Disagree 17% **Agree 50%** **Neutral 33%**

Figure 3.
"The teaching I have received so far in IMT has prepared me for the role of medical registrar."

Pre-Course
Confident 17% **Unconfident 33%** **Neutral 50%**

Post-Course
Neutral 17% **Confident 83%**

Figure 4. Overall, how confident do you feel in stepping up to the Medical Registrar Role?

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QI Foundation: Putting Quality into Quality Improvement

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NHS — Sandwell and West Birmingham Hospitals — NHS Trust

QI IN HEALTHCARE: The Challenges

- Quality Improvement (QI) in healthcare has a key role in improving patient care and outcomes.

- The GMC states that doctors *'must take part in systems of quality assurance and quality improvement to promote patient safety'*. As such, Clinical Audit (CA) and Quality improvement (QI) are key components of the Foundation Programme curriculum.

- Despite this, training in QI does not consistently feature in medical school curricula, and postgraduate training in QI methodology remains variable. Consequently, lack of knowledge of QI methodology remains a significant barrier to undertaking successful QI for junior doctors, and QI work is often considered as secondary importance compared to one's clinical role.

- The need for improved QI training for junior doctors has been acknowledged, and the Healthcare Quality Improvement Partnership recommends that hospital trusts should provide Foundation doctors with half-day teaching sessions on each of clinical audit and Quality Improvement, as a minimum.

- However, within our trust, there is still only limited training on QI methodology and a lack of formal support with project implementation. With this in mind, we sought to improve access to QI training for foundation doctors within our trust, by developing a QI training programme aimed at enhancing knowledge of QI methodology and tools and therefore removing this as a barrier to undertaking successful QI.

AIMS

1) To improve understanding of QI tools and methodology amongst Foundation Doctors.

2) To improve the confidence of Foundation Doctors in undertaking audit & quality improvement.

3) To improve awareness of what help is available when undertaking QIP and audit.

4) To optimise enjoyment and engagement with QI teaching, and to consolidate learning by putting theory into practice.

PROJECT DESIGN

Training on CA and QI was delivered to Foundation Doctors (FY1 & 2) and Advanced Care Practitioners (ACPs) over 2 sessions, facilitated by the Chief Registrar, with speakers from the Clinical Effectiveness and Improvement teams.

Sessions:

✓ Covered the difference between CA and QI, QI tools and methodology, how to undertake CA & QI (including how to register a project) and how to plan an improvement project.

✓ Were interactive: a mix of taught work, small-group work and practical activities.

Following the training sessions, participants undertook a QI project in groups of up to 3 people, with support from the Clinical Audit and Improvement teams, including 4-weekly drop in sessions.

Projects were presented at a poster presentation event at the end of the year. Everyone was encouraged to present, even if they had not completed their project. This was in order to acknowledge their work and to discuss ways to overcome any barriers that may have arisen.

An additional session was held, titled "How to get your QI work published", which included a presentation from a BMJ representative as well as tips and advice from trainees who had prior success in publishing their work.

Pre- and post-course data were collected to ascertain the impact of the training.

RESULTS

- The QI programme was attended by 21 delegates (10 FY1s, 5 ACPs 4 FY2s, 2 other).

- We found increased confidence in knowledge and understanding of QI tools following the programme, as demonstrated in Table 1 and Graph 1.

- Prior to the programme, 80% listed lack of knowledge of or confidence with QI methodology as a barrier to them undertaking QI & audit. This fell to 8% following the course.

- Feedback from the course was overwhelmingly positive – 100% of participants reported that they were likely or very likely to recommend the course to others and 84% reported that they were likely or very likely to use to tools they had learnt about in future. Free text feedback can be seen in Box 1.

Table 1: Comparison of pre- and post course data

Question	% answering yes	
	Pre-course	Post-course
Have you had any training in audit or QI previously?	65%	N/A
Are you aware what support is available to you when undertaking QIP or audit?	0%	85%
Do you know how to register a QIP or audit?	25%	100%
Are you aware of the difference between QI and audit?	70%	92%
Do you know what a fish-bone (cause and effect) diagram is?	15%	92%
Do you know what process mapping is?	15%	100%
Do you know what a driver diagram is?	0%	100%
	% answering good/excellent	
How would you rate your overall understanding of audit and quality improvement?	0%	92%
	% answering very much	
To what extent have the sessions increased your confidence in being able to undertake a successful project?	N/A	77%
	% answering likely/very likely	
How likely are to use the tools that you have learnt about when undertaking projects in future?	N/A	84%

Box 1: Anonymous free text feedback from attendees

- *"Very interactive and helpful course with practical guidelines to offer support to develop our project"*
- *"Really useful practical advice. I feel very supported going forward and know who to ask if any concerns"*
- *"I feel much more confident to start a QIP and feel I have the tools to conduct it with good methodology"*
- *"I feel much more enthusiastic about QI now that I know more about how to do it"*

Figure 1: Spider Chart showing change in knowledge following the QI training programme
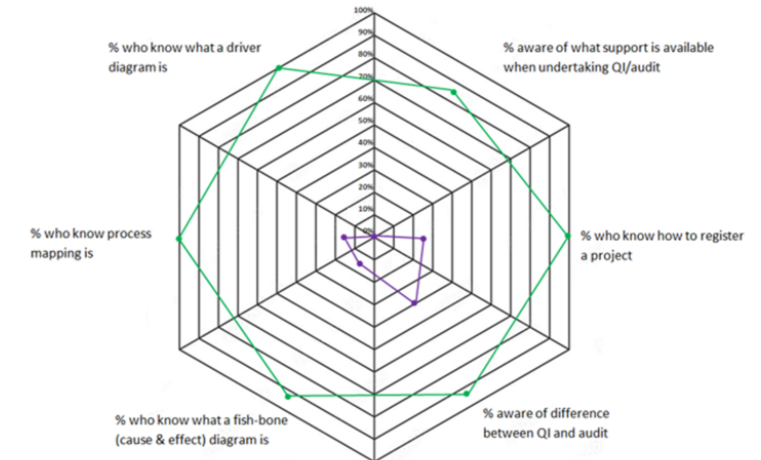
SIGNIFICANCE AND IMPACT

- We have demonstrated improved knowledge of QI tools and methodology following the implementation of a dedicated QI teaching programme.

- The programme led to improved confidence in undertaking QI and by the end of the course, lack of knowledge of QI methodology was no longer considered to be a significant barrier to undertaking QI.

- Following the poster presentation event, delegates were signposted to link up with individuals working on the wider trust objectives relevant to their project area, which will allow for collaborative working and will help to promote continuous QI.

- In view of the success of this pilot programme, the course is being rolled out to include junior doctors at all levels. The course will be adapted as appropriate in response to feedback received from the first cohort. The ultimate goal is to provide training to other MDT members, in the hope that we can encourage a fully multidisciplinary approach to QI in the future.

CONCLUSION

- Quality improvement is vital to improving patient experience and outcomes, and junior doctors have a key role in this process.

- Lack of understanding of QI methodology is a known barrier to undertaking QI.

- The provision of QI training for foundation doctors improves confidence in undertaking QI projects.

- Hospital trusts should therefore provide QI training to their junior doctors as standard practice.

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Near-peer MRCP PACES Teaching: Improving Confidence, Skills And Satisfaction

Maria Francisca Rocha [1], James Bell [1], Jonathan Spencer[1], Benjamin Sacks [1], Charles Coughlan[1]

1. University College London Hospitals (UCLH) Trust, London, UK

Background and aims:

The MRCP Practical Assessment of Clinical Examination Skills (PACES) is a critical progression point in medical training. It is notoriously difficult, with overall pass rates of only ~50%[1]. Because of clinical pressures, bedside teaching sessions can be infrequent and inconsistent. We identified local issues in supporting and mentoring PACES candidates. Inspired by others[2,3], we sought to sustainably improve teaching provision in our large NHS Foundation Trust.
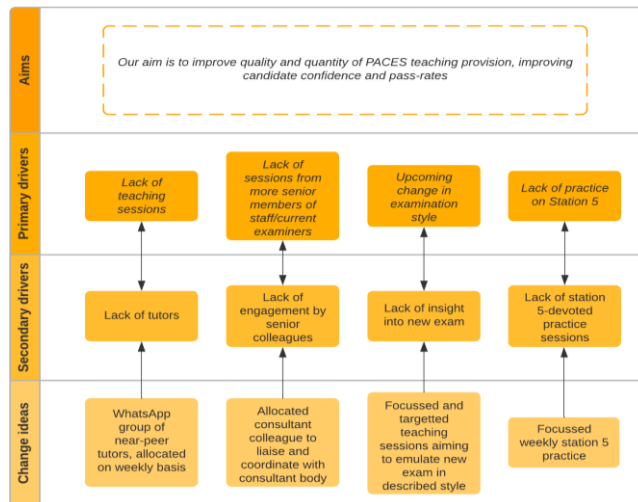
Figure 1: Driver diagram

Methods:

We sought to improve PACES teaching from October 2022 until present. We surveyed PACES candidates on baseline teaching provision to identify areas for improvement, and devised a driver diagram based on this (Figure 1). We received ongoing survey feedback over 3 examination diets and PDSA cycles. We developed a near-peer teaching programme, to provide a sustainable teaching model less dependent on senior staff, with tutors allocated on a weekly basis to deliver 2-3 sessions a week. A consultant colleague organised weekly consultant-led teaching. We provided Station 5-focussed sessions, since this was highlighted as a high-stakes station.
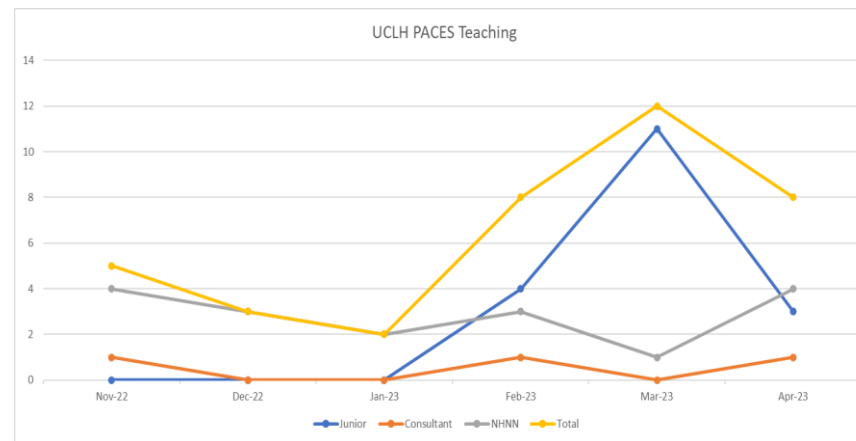

Figure 2: Teaching sessions per month (hours)

Results:

Prior to the project, 100% (n=11) of candidates had attended <1 hour of teaching. 71% of candidates (n=7) surveyed following the 2023/01 diet attended 3-4 hours of teaching per week (Figure 2). Qualitative feedback was overwhelmingly positive, and highlighted the utility of a consistent teaching programme in improving confidence prior to the exam.

Discussion:

A systematic approach has improved quantity and quality of PACES teaching provided. Work is ongoing to improve candidate confidence prior to the introduction of a new exam format later this year.[4]

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Improving Medical Student Experience And Engagement Through A Team-Based Placement Structure And Comprehensive Induction

Dr Rory Fairhead*, Mr Moataz Ewedah, Mr Robert Buhain

Introduction

Medical student placements are crucial in shaping the future of healthcare professionals, fostering both clinical knowledge and a sense of belonging within the medical community.

Amidst rapidly changing health systems and pressures on students, placements are increasingly being shortened and spread across several hospitals, endangering this sense of belonging[1].

This project aimed to enhance the quality of medical student placements in a surgical department by implementing a tailored induction process and team integration strategy akin to the American model student integration in surgical firms[2]

Methods

Data was collected from 3rd year students from a London medical school embarking on their first year of hospital placements. Prior to the intervention, placements were task based - students were allocated to rotate through 12 defined activities such as ward round, clinic, on-call, theatre etc. across multiple sites. Students often felt isolated, disoriented and ignored during these placements and rated the activities poorly on whether they were educationally useful and enjoyable. Furthermore, students highlighted that they did not feel part of the surgical team and as a result received less formal and bedside teaching than desired.

Intervention

Two interventions were developed to address this. The first was to restructure the placement with individual timetables which allocated students to particular surgical firms, allocating them to attend ward rounds, clinics and theatres lists with this team. The second was an induction document which set out the structure of the department, contact details, and signposting educational and sign off opportunities. After this new placement structure was implemented, anonymous feedback was collected using Likert scales, multiple choice answers and free text response and results compared. 24 responses were collected in total.

See below for placement structure prior to intervention (top), and after intervention (bottom, shortened
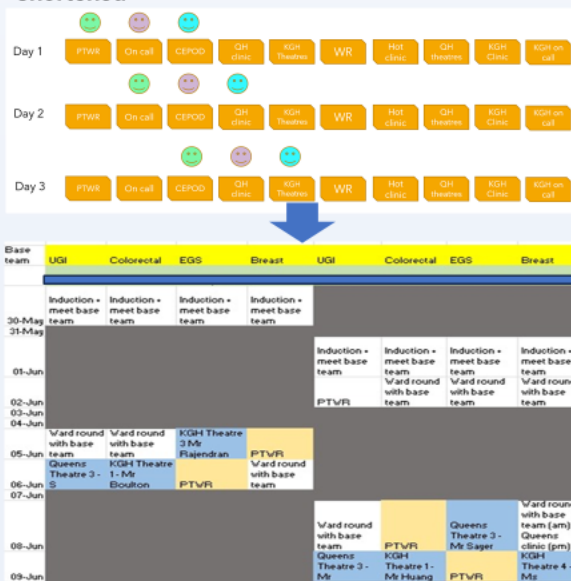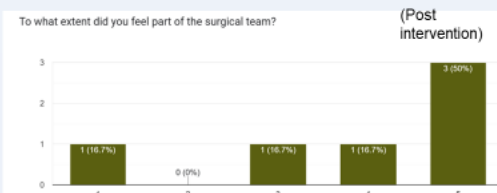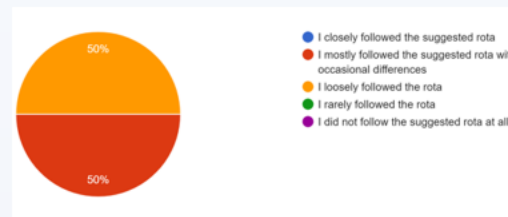

Results

After the intervention, student's ratings of how educationally useful different activities were improved in 4 out of 5 domains. Averaged scores improved from 3.4 to 3.9 out of 5 (Mann-Whitney U test $p<0.05$).

Activity	Rating/5 (bold font = rating post intervention)
Clinic	(3)3.9
Theatre	(4.5)3.3
On call	(N/A)3.2
WR	(3.8) 3.6
PTWR	(4.5) 3.1

Furthermore students felt the surgical team to be more helpful and supportive post intervention (4.3 vs 3.9/5), felt more part of the surgical team (3.8 vs 3.4/5) and rated their placement more highly on average (7.8 vs 7.2/10), though not significantly at p=0.05.

Please rate how supportive & helpful you found the QH surgical team to be (Post intervention)

To what extent did you feel part of the surgical team? (Post intervention)

Students had good adherence to the new placement structure and found the induction document helpful.

- I closely followed the suggested rota
- I mostly followed the suggested rota with occasional differences
- I loosely followed the rota
- I rarely followed the rota
- I did not follow the suggested rota at all

Conclusions

This project shows how a team-based placement structure and comprehensive induction document can benefit students across a range of subjective measures and has led to the adoption of this new structure for future placements. Future research could focus on the impact of this new model on objective measures of attainment, staff perspectives and patient care.

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NHS

A novel course using highly realistic manikins to teach end of life care to final year medical students

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1. Introduction

The General Medical Council expects newly qualified doctors to make appropriate clinical judgement around the care of patients at end of life.[1] However, it is well recognised that newly qualified doctors feel under prepared to deliver end of life care.[2]

To address this, we designed a novel course focussing on key areas of end of life care as detailed in the Foundation Programme curriculum.[3]

Figure 1: Highly realistic end of life manikin

2. Course design

- Interactive 2.5hr session for final year medical students

- Follows the journey of a patient at end of life

- Addresses key skills including sensitive communication, delivering individualised care and verification of death

- Use of highly realistic end of life manikins for students to interact with (see figure 1)

- Use of a communication role-play by faculty to mimic a conversation between a doctor and relative

3. Methods

- The course has run twelve-times over a two-year period

- 98 final year medical students have attended

- All students have been evaluated with pre and post course questionnaires assessing confidence in key areas of care of the dying using a 5-point Likert scale (0 = not at all to 4= very much)

- Free text comments were also gathered

4. Results

Confidence levels improved in **all 5 areas of assessment** after the course (see graph 1). Free-text feedback from candidates reported the course was informative, highly relevant, engaging, and a safe environment for learning.
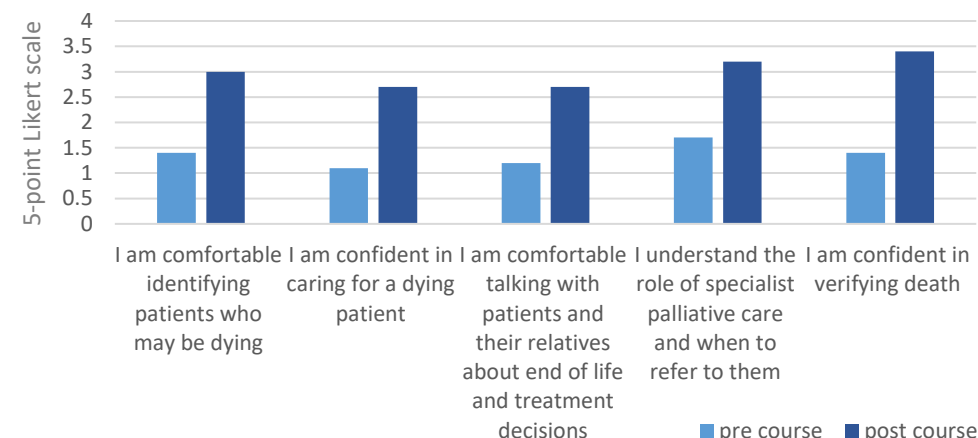
Graph 1: Mean scores on Likert scale

5. Conclusion

We have developed a course to better prepare final year medical students for caring for patients at end of life, and demonstrated that it increases their confidence in managing these patients. Our course has received overwhelmingly positive feedback, and we hope to expand the delivery to more sites in the future.

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3. UKFPO. UK Foundation Programme Curriculum 2021. UKFPO, 2021. https://foundationprogramme.nhs.uk/curriculum/ [Accessed 23 August 2023].

Maximising Clinic experience in internal medicine trainees

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NHS
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NHS Foundation Trust

Introduction

Clinic experience is a crucial component of internal medicine training. IMT curriculum requires a minimum of 20 clinics attended in IMT1, aiming for 40 by the end of IMT2 and 80 by the end of IMT3. This must be achieved for ARCP outcome.

Clinic time also give trainees opportunities to review patients in different clinical approach and manage conditions which are not normally encountered on the ward.

Aims

1) To improve clinic attendance
2) To meet curriculum requirement for ARCP
3) To improve training satisfaction in managing clinics.

Methods

1) Obtained baseline data of clinic attendance and identified potential barriers by generating a survey among IMT trainees based in SGH
2) Implementation of allocated clinic time
3) Introduction of a clinic schedule to outline which speciality clinics are running and when, who to contact etc.

Initial survey revealed that 88% felt that they did not have enough opportunities to attend clinics and identified common barriers as:

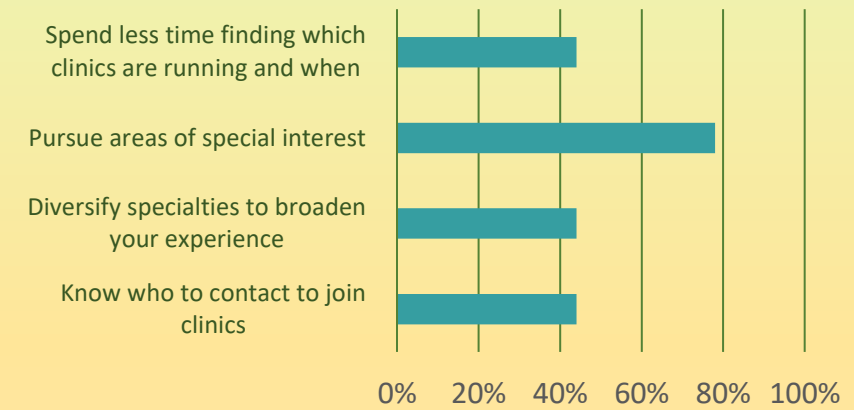Trainees highlighted the following as benefits of having a clinic schedule:
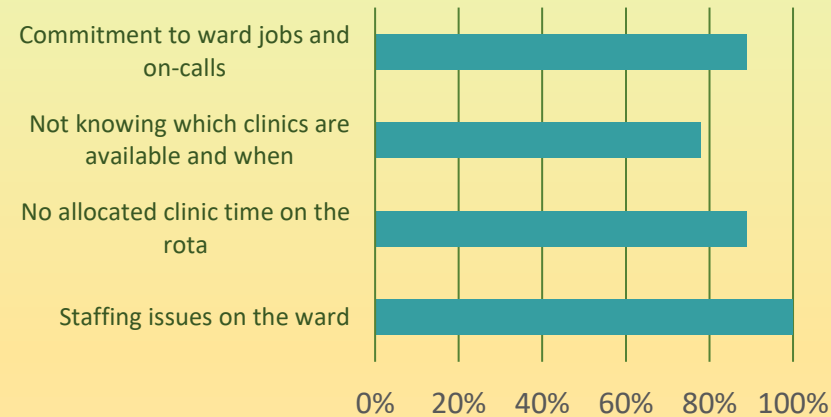
Results

After implementation, 100% achieved minimal clinic attendance required for ARCP and found the clinic schedule useful. However, 56% found that they did not have enough opportunities to perform workplace-based assessments during clinics.

Analysis of feedback gave even more insights into barriers which included : no room availability for trainees to review patients, consultant's workload and limited time in clinic leading to only observational experience.

Conclusion

Implementation of allocated clinic time with a schedule is an effective way of increasing opportunities for trainees to attend clinics, increasing outpatient experience, and meeting curriculum requirements.

Workforce development and wellbeing posters

October 2023

Evaluation Of The Delivery Of Pulsed Intravenous Methylprednisolone To Patients With Interstitial Lung Diseases

Alexander Emery [London,UK][1], Nazia Din[1], Kritchai Vitipongsatorn[1], Dhivya Ilangovan[1], Abigail Harrison[1], Richard Hewitt[1], Melissa Wickremasinghe[1]

[1]Imperial College Healthcare NHS Trust

NHS
Imperial College Healthcare
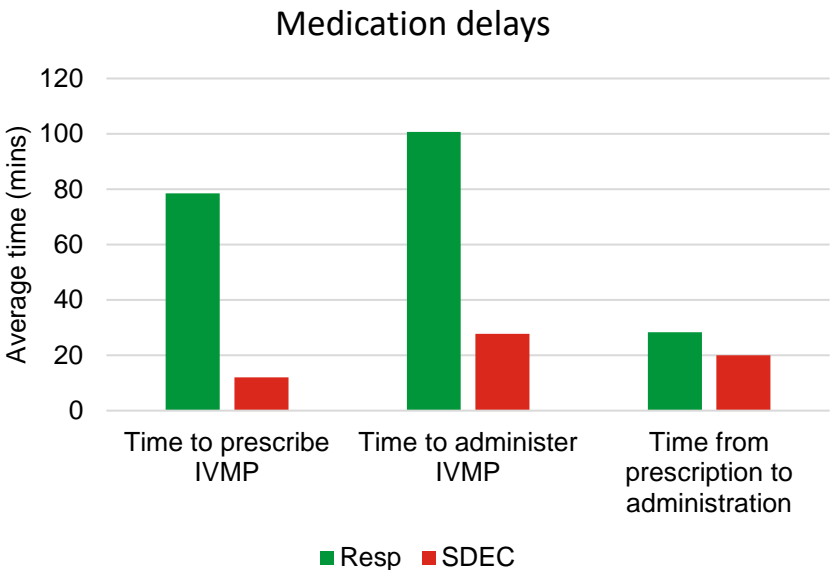NHS Trust

Introduction

Interstitial Lung Diseases (ILDs) are a spectrum of lung disease which cause inflammation and/or progressive scarring to the lung parenchyma. Pulsed Intravenous (IV) Methylprednisolone (MP) is given for many progressive primary ILDs with an inflammatory component. Pulsed IVMP can be safely given in an ambulatory setting and is occasionally currently delivered on an informal ad hoc basis through our Same Day Emergency Care (SDEC) Centre, or in an inpatient environment.

Materials and Methods

We created a data collection tool to capture all patients with ILD who had been referred to SDEC for IVMP over an 8-month period, and recorded whether historical locally agreed standards were being met. We also recorded a number of factors that affected patient flow and experience in SDEC.

We then worked collaboratively with the planned and unplanned care teams in Respiratory and Emergency Medicine / SDEC to design and implement a formal pathway for these patients. After a year, we reaudited the same criteria to compare our performance.

Results and discussion

Medication delays — Average time (mins) for Time to prescribe IVMP, Time to administer IVMP, and Time from prescription to administration (Resp vs SDEC).

As well as a number of criteria that were being incompletely met, we identified the potential for increased efficiency if the SDEC team take the lead for IVMP prescribing on the day, rather than having to contact the on-call Respiratory team who often would not know the patient in question.

Time in department — Average time (mins) Before pathway implemented and After pathway implemented.
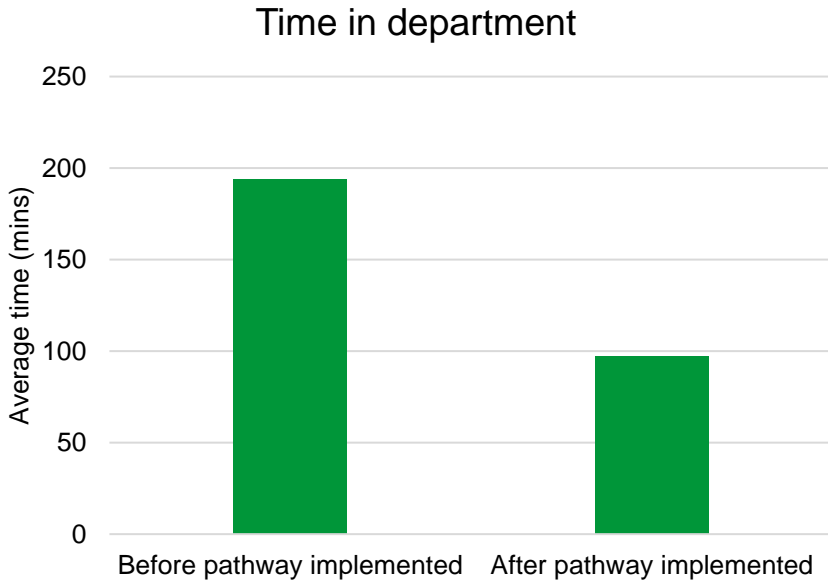
Conclusion

Our new pathway has standardised and streamlined the treatment of patients with ILD requiring pulsed IVMP in an outpatient setting in our Trust and can serve as a model for other services.

"Break the Block"

Minimising Burnout In Acute Medicine For Postgraduate Doctors

Dr F Hoskins, Dr H Niaz
With thanks to Dr Nel and Stephanie Beere

Background – *"the acute block"*

At Southmead Hospital in Bristol, six continuous weeks of acute medicine consisting of on-call shifts form a mandatory part of the rota for postgraduate doctors (PGDs) rotating through medical specialties every 4 months.

Anecdotal feedback from PGDs over the years has highlighted dissatisfaction and burnout.

Objectives

- To explore the levels of burnout and its reasons
- Implement an alternative acute block

Methods

Qualitative survey feedback from 11 PGDs and discussion at PGD forums. Alongside senior and rota staff, alternative rotas were devised.
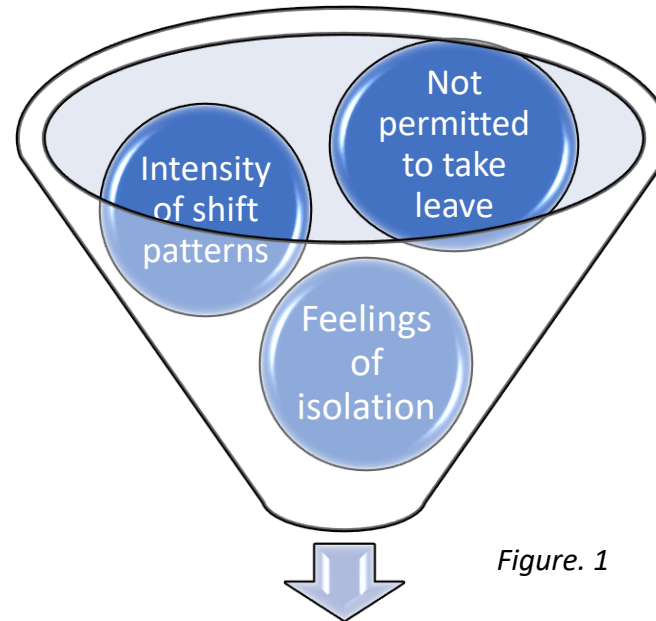

Intensity of shift patterns

Not permitted to take leave

Feelings of isolation

Figure. 1

High levels of burnout

Alternative rota format

6 week block

Figure. 2

2 week block | 2 week block | 2 week block

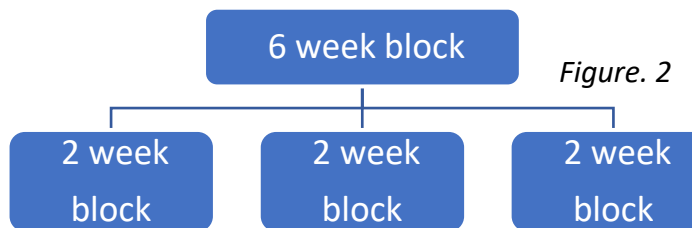## Results

High levels of burnout and their reasons were identified (fig. 1). Findings were distributed amongst the acute medical divisional leads, the Guardian of Safe Working, clinical directors, rota staff and trainee/BMA representatives. Feedback showcased that '3 x 2 week' block was favoured with almost all PGDs, potentially reducing outcomes of burnout (fig. 2).

Conclusion and future

The 6-week acute block accounted for significant burnout. Implementing change to trainee rotas was much favoured. Feedback will be collected after 4 months of the alternative rota and reviewed analysed to determine its impact.

October 2023

Induction programme for new International Medical Graduates at University Hospitals Sussex

Pereira, R [1]; Middleton, B [1]; Beckley, S [1]; Laffan, J [1]; Yeo A, Choudhary, A[1]; Alhashimi, N [1]; Ahmed, S [1]; Nweze, C [2]; Wusu, M [1]

1 University Hospitals Sussex NHS Foundation Trust ; 2 Sussex Partnership NHS Trust ;

NHS University Hospital Sussex NHS Foundation Trust

Introduction

One in three new doctors joining the NHS graduated abroad. This could increase to two in three by 2030[1]. On relocation, these doctors face a myriad of problems and seem to have a higher rate of GMC referrals due to inadequate induction[2,3]. Adequate support in their transition to work in the UK directly impacts their wellbeing, career progression as well as their overall function within the NHS. National guidelines for IMG induction[4,5] have been released in 2022 but these still rely on local effort to be established.

Materials and methods

WhatsApp group	IMG buddy	IMG reception and map
IMG Handbook - Table of Content [QR code] SCAN ME		**IMG IRIS Induction Page**
-Visa and immigration -University Hospitals Sussex -Public transport and driving -Finances and discounts -School placements -Supermarkets -Working at an NHS hospital -Training and portfolio Exciting Brighton, Haywards Heath, Worthing and Chichester	Exploring Sussex and the UK -Faith and spirituality -Health and wellbeing -A word for the job-hunting spouse -Facebook groups, BMA material, blogs and other links -Training, CPDs and career progression -IMG checklist	SBAR handover DNA CPR discussion Exploring a mistake Datix guide Breaking bad news Death verification NHS e-portfolio Horus portfolio How to take bloods

Results and Discussion

- Positive feedback and progressing
- Important step in the creation of a local network system for IMGs
- Source of accurate information for IMGs and their clinical and educational supervisors
- Plans of adapting material for other international health care professionals and acquiring funding for social events
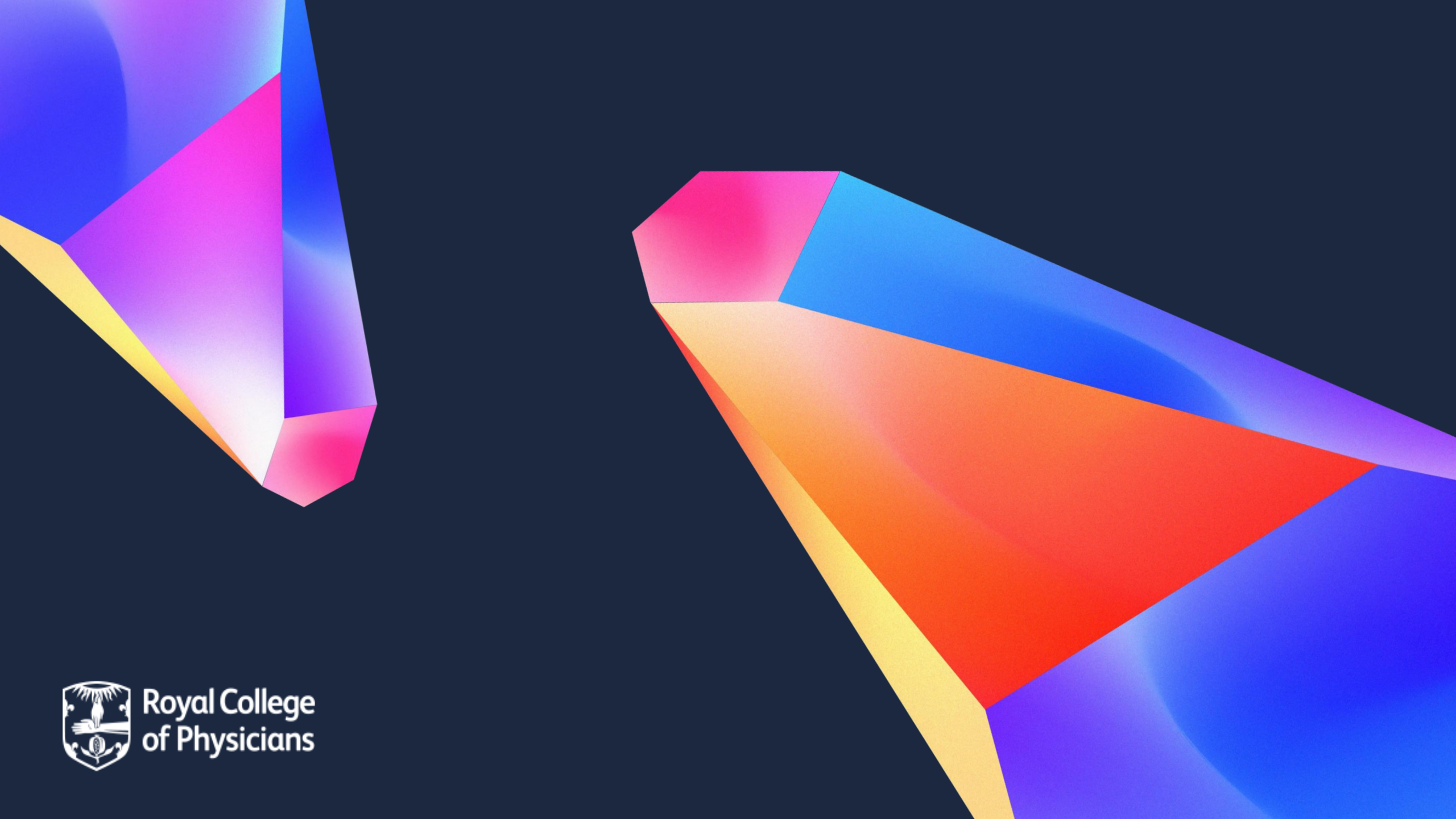
Conclusion

Providing IMG specific induction process has allowed an easier adjustment into the NHS for new IMGs. It is hoped that it can be replicated across UK to improve wellbeing and workforce development.

Scratch off map showing origin countries of IMGs at UHS (Purchased from myglobalwalkabout.com)

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5. Hodkinson J and Lok P. NHS launches first standardised induction programme for international medical graduates. BMJ 2022;378:o1624.
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