

The RCP chief registrar scheme

2018/19 yearbook



Foreword

It gives me great pleasure to introduce the yearbook for our 2018/19 cohort of chief registrars. This flagship leadership scheme continues to bring great pride to the RCP as we watch the participants flourish in their leadership roles.

This year was the largest cohort to date, with 56 chief registrars enrolled onto the scheme. I am delighted that more and more trainees are looking to step into this exciting leadership position to improve patient care, support their peers, and further their own development.

Each year the chief registrars have the opportunity to take on projects in their own organisations. Here, the chief registrars have an opportunity to reflect on the vast range of projects they have been working on from rota redesign, weekend handovers and medical outliers to name just a few. It is to be admired how chief registrars get stuck into the difficult issues facing our profession and our services. In just 12 months, they make a considerable difference and demonstrate huge value to their organisations.

Chief registrars tell us that visibility of their role is a crucial element in helping to bridge the gap between junior doctors and senior organisational leaders. With that in mind, it was great to see so many chief registrars share their learning and present their projects at Medicine 2019. It was wonderful to hear that their projects are still ongoing with the opportunity for them to be scaled and spread even further.

The RCP chief registrar scheme is going from strength to strength and we are proud of what our chief registrars have achieved and will continue to achieve going forward. We wish them every success for the future and we hope they stay involved with the RCP and continue to share their learning with us.



Professor Andrew Goddard
President, Royal College of Physicians

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With thanks to the following 2018/19 chief registrars who were unable to participate in the yearbook:

- > Wendy Baird
- > Samantha Carvey
- > Emma Drydon
- > Amy Forrester
- > Amber Hawksley
- > Peter Jeffery
- > Richard McCrory
- > Sunit Raja
- > Seren Williams



Rina Adhikary

Organisation: Gloucestershire Hospitals NHS Foundation Trust

Grade: ST6

Specialty: Acute medicine

Mentor: Mark Pietroni

Maybe naively, I used to assume that people choose a particular course of action because it is the right thing to do and then would later puzzle over why I wasn't successful at implementing a change. This year has taught the importance of assessing what drives different people and incorporating some of these aspects when trying to get them to buy into the overall vision. The chief registrar role has empowered me to question statements and decisions regardless of the seniority of the person making them, which was valuable for all of us.

Optimising junior doctor staffing in the medical division

Aim: The overall aim was to reduce the amount spent on locum staffing by the medical division.

Of the many projects I took on this year, the medical rota review project is perhaps the most beneficial to the trust. The aim of this project was to optimise the rotas to enable adequate junior doctor cover of both the acute take and the inpatient bed base, while allowing for educational opportunities and reducing sick leave.

Historically, sick leave has been high, there are on-call rota gaps and the medical wards have been staffed sparsely. This was exacerbated by a lack of coordination between the foundation doctors, core trainee and registrar rotas, such that multiple members of the same team may have been on-call at the same time.

I worked collaboratively with the chief of the medicine division, head of school and chair of the junior doctor forum. We surveyed the juniors and found their objections to the current rota were felt to be arduous acute blocks and scheduled off days clashing with weekly education sessions.

I redesigned the whole rota from foundation year 2 doctor (FY2) to core training year 2 (CT2) level and wrote a new trust doctor rota. Following the recommendations in the RCP safe staffing report we looked at our own demand and capacity assessments of the acute medical unit, and of the inpatient wards, and tried to optimise staffing at peak demand times.

This year has taught me how important it is to assess what drives different people.

Finally, I modelled the staffing for the whole year and allocated trust doctor posts to areas that were lacking in trainees.

The new rotas start from August 2019. The trust has ongoing plans to track the locum spend compared with the last financial year. We expect that the forward planning and clear oversight of the system will enable us to reduce the amount spent on long-term locums.



Andrew Allard

Organisation: Great Western Hospitals NHS Foundation Trust

Grade: ST6

Specialty: Rheumatology and general internal medicine

Mentor: Dr Carolyn Mackinlay

The chief registrar programme has been excellent at allowing me to explore the issues around different leadership preferences and how these can be used effectively to facilitate better teamworking in the NHS. This has been crucial in our work in medical outliers which has involved implementing change across different divisions, as well as between different teams involving both clinical and non-clinical staff. The programme has allowed me to develop key skills in quality improvement and has given me the time and opportunity to take on a trust-wide project.

Caring for medical outliers

Aim: To improve the quality of care for patients who are looked after on non-medical wards and to improve staff experience.

Improving care in medical outliers has been both challenging and rewarding. During the winter months we were able to improve patient safety and continuity of care by establishing an effective handover process and by redistributing the existing junior doctor workforce. We also increased the number of medical consultants appointed specifically to the care of these patients, and improved communications between the outlier wards and the medical teams by obtaining dedicated digital enhanced cordless technology (DECT) phones.

Despite these changes the system has remained largely reliant on a temporary staffing model. Throughout the process we have collated data including outlying patient numbers and length of stay of outlier vs 'inlier' patients. The system has remained fragile and particularly susceptible to changes in staff availability and retention, particularly towards the end of what has been a difficult winter period.

As a result of the work we have done we have been able to shine a spotlight on the challenges (in patient and staff experiences) that are faced in looking after patients as medical outliers, and we have been able to take this to the Executive Board level. We have established a working group with involvement from the highest level within the trust who are now looking at redesigning the way medical outliers are cared for in our hospital based on our recommendations.

We have been able to present our work at the south west 'Next generation leaders' conference as well as at the RCP conference 'Medicine 2019'.

As a result of the work we have done we have been able to shine a spotlight on the challenges that are faced in looking after patients as medical outliers.



Aruna Arjunan

Organisation: Dorset County Hospitals NHS Foundation Trust

Grade: ST7

Specialty: Renal medicine and general internal medicine

Mentors: Miss Audrey Ryan and Professor Alastair Hutchison

Through the chief registrar training, I have acquired fine leadership and management skills that helped me evolve myself from a pure clinician to a clinical leader with a passion for quality and service improvement. The scheme has increased my self-recognition and has given me great, in-depth insight into my own leadership style, and my strengths and weaknesses. I have felt empowered in my ability to use my personality style positively to lead change, and influence and engage stakeholders.

Timely completion of electronic discharge summaries

Aim: To improve electronic discharge summaries completion within 24 hours of patient discharge.

The NHS England Standard Contract guidance insists that discharge summaries should be completed and sent to GPs within 24 hours of discharge. Although our trust aims for 98%, we are currently achieving 75–80% within 24 hours.

Challenges:

Viewing electronic discharge summaries (EDS) as just an administration job of no learning value, lack of awareness of its impact on patient safety, poor notes flow, general resistance to making EDS mandatory at patient discharge due to concerns about impedance to patient flows and rota gaps.

Interventions:

1. Introduced auto-generated incomplete EDS list for all specialties and promoted new culture of daily review of this list during board-rounds.
2. Promoted awareness of new list and the importance of timely EDS completion through educational talks in induction, teachings and governance meetings.

3. Modified dashboard view of EDS system to improve visibility and reduce errors.
4. Piloted mandatory completion of EDS at patient discharge in non-acute medical wards.
5. Mentored trainees on quality improvement in selected specialties.
6. Consultant league tables on EDS completion rates.

Results:

More teams are embracing the new culture. The completion rates maintained at 80% this winter, whereas it dipped to 65% in 2017. The most challenging acute medical unit completion rates have improved from 70% to 80%, despite its rapid turnover. This is an ongoing project. We are yet to see full results.

Mandatory e-learning was introduced during induction, promoting patient awareness and empowering patients to ask for EDS. Further plan, do, study, act (PDSA) cycles on previous interventions will be the next steps.



Anuja Bambaravanage

Organisation: Oxford University Hospitals NHS Foundation Trust

Grade: ST7

Specialty: Acute internal medicine

Mentors: Dr Sudhir Singh, Dr Jordan Bowen and Dr James Price

The chief registrar development programme has helped me to understand the NHS as a whole and its most powerful asset: the workforce/people. I have valued engagement with organisational leadership at various levels, understanding the challenges, and most importantly systems thinking and intelligence. Also acting as an agent of change and being that missing link between managers, non-clinical staff and doctors in training, and bringing people together for making things better, are other elements I have valued.

1. Web- and app-based clinical messaging and pager replacement
2. Point-of-care ultrasound service in ambulatory care and acute general medicine

Aims: Remove dependence on bleeps and social media for communication, improve clinical governance, save clinician time, financial savings, improve patient care, supplement rapid clinical decision making, reduce length of stay and improve experience for trainees.

Achievements of project 1:

- > Savings of >£150,000 per year by not renewing current pager system contract and more by not upgrading the ageing infrastructure (transmitters).
- > Benefits for wider workforce have included:
 - easy, direct, contact and dialogue
 - instant contact – no more waiting around for ‘bleeps’ to be answered, calling switchboard, phone ping-pong
 - knowledge of when a message has been read and received
 - ability to share photos/images and patient information with confidence – rather than risk breaching patient confidentiality by using unsuitable apps
 - knowing who’s on-call by integrating with rotas
 - use on the move.
- > Auditing, clinical resource management – diverting workforce to areas of need based on priority/demand and capacity.
- > Saving clinician time and focusing on patient care.
- > embracing technology developments to improve patient care at the bedside
- > reduced length of stay
- > improved patient experience
- > developing point-of-care ultrasound (POC US) skills which will help with clinician recruitment and retention
- > implementing POC US will make ambulatory units forerunners in the country
- > delivery of a high-quality and efficient service in an ambulatory setting
- > POC US would reduce the number of patients requiring X-rays/scans thus reducing patient exposure to radiation
- > if POC US reduced the number of radiology scans required daily by five it could save £100,000 a year (estimate of £50/radiology scan)
- > rapid clinical decision-making leading to improved patient flow and reduced length of stay allowing for more patients to be treated outside of the emergency department.

These are ongoing service development projects. The Care Quality Commission (CQC) report has recognised the chief registrar programme at John Radcliffe Hospital as an area of outstanding practice.

Achievements of project 2:

- > securing funding and purchasing two new ultrasound machines



Katie Bell

Organisation: London North West University Healthcare NHS Trust

Grade: ST7

Specialty: Acute medicine

Mentors: Jon Baker

The chief registrar scheme has given me the confidence to lead a major project. I have become more aware of the attributes I have which will make me a leader, and I have been able to develop skills that were lacking. I have been able to provide a link between management and junior doctors, communicating opportunities and ideas for improvement both ways. As a final year trainee, the programme has prepared me well for the next challenge of becoming a consultant and continuing my improvement work within the role.

Designing the best possible acute medicine model

Aim: To develop an acute medicine model to improve flow through our acute floor.

I have been involved with a number of projects over the course of the year including joint clerking, setting up a mentoring scheme and improving junior doctors' working lives. The project that I have spent the majority of my time working on is developing our acute medicine model.

As the lead on this project, I have held a number of sessions and engaged with a wide variety of stakeholders. We now have a full appreciation of where our opportunities for

improvement lie. A business case is pending, and next steps include designing a new model, and putting this in to practice.

We envision positive effects on patient and staff satisfaction, length of stay, and flow through our acute floor.

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Sanjay Bhandari

Organisation: University Hospitals of Leicester NHS Trust

Grade: ST6

Specialty: Cardiology

Mentor: Dr W Nicolson

The bespoke chief registrar programme was a fantastic platform to cement core leadership skills, but also to further my understanding of the importance of the different personality traits that define everyone, critical to instigating a collective change. The opportunity to actively engage with senior management in meetings and offer a trainee's perspective and possible solutions was gratifying. The collaboration with individuals from the complex layers of the NHS structure was insightful and unattainable had I persisted with pure clinical training alone.

Simulation: Dawn of a new era in education

Aim: To improve the education and training for fellow junior doctors.

Glenfield hospital is the standalone tertiary centre for cardiorespiratory medicine in Leicester. Despite a selected take, the workload can be demanding and can impact on training and morale. I devised a series of low-fidelity simulation workshops, tackling key cardiorespiratory emergencies, eg supraventricular tachycardia / pulmonary embolism, for the junior doctors. The feedback from the workshops was inspiring, such that there is now a dedicated simulation slot every week.

The junior doctors rotating through cardiology were comfortable in managing patients with acute coronary syndrome, however had limited knowledge of what a coronary angiogram would entail and its potential complications. I devised a series of high-fidelity coronary angiogram simulator workshops, to allow the juniors hands-on experience, while reinforcing key knowledge regarding indications, patient preparation and dealing with complications. The juniors found this an invaluable experience and had greater confidence in managing such patients, and this has now become a regular workshop.

For cardiology registrars pericardiocentesis is a rare but mandated 'sign-off' competency. I organised the first Glenfield pericardiocentesis course with a simulation-based scenario, allowing hands-on experience and the opportunity for a competency assessment. This was met with encouraging feedback from the trainees and the training programme director (TPD), such that this will become a yearly event, with the prospect of expanding to other local cardiology centres.

This was an enriching year, from chairing junior doctors' forums, to sharing ideas in the action learning sets in the chief registrar modules. I have cultivated a realism that the small incremental gains can have a lasting impact on training, but more importantly on morale.

The juniors found this an invaluable experience and had greater confidence in managing such patients, and this has now become a regular workshop.



Amy Davies

Organisation: University Hospital Birmingham

Grade: ST6

Specialty: Geriatric medicine and general internal medicine

Mentors: Dr Z Wyrko

One of reasons I applied for the chief registrar programme was because I knew very little about how hospitals actually run. We all come across problems and challenges everyday that we would like to improve, but understanding the steps involved to ensure change is felt across an organisation is vital for sustainability. The chief registrar role gave me the opportunity to gain this knowledge, in addition to management and leadership experience that has been especially crucial towards the end of my training.

Formation of a Junior Doctor Wellbeing Steering Group

Aim: To enable collaborative working among individuals passionate about junior doctor wellbeing.

Junior doctor wellbeing has become an increasingly hot topic and reports by the British Medical Association, RCP and Health Education England have all raised concerns. Wellbeing initiatives are numerous and of varying success. What is recognised is that hospitals need to be prioritising the development of a wellbeing culture within their workforce.

A scoping exercise of ongoing initiatives indicated that they were either individually led or as a result of small groups working independently within the hospital. The aim of the steering group was to bring individuals together to enable collaborative working. At this stage members were predominantly consultants. Invites were then extended to members of the education team, junior doctor support team, occupational health, nursing colleagues and junior doctor representatives.

There are currently 18 members of the Junior Doctor Wellbeing Steering Group. Meetings are currently held quarterly.

Ongoing initiatives include:

1. small group reflective practice groups facilitated by a consultant psychologist to discuss difficulties faced as a junior doctor
2. implementation of Schwartz Rounds (multiprofessional reflective practice)
3. development of a 'buddy system' for new doctors joining the hospital
4. development of junior doctor welfare officer (application for funding currently in progress).

A single wellbeing initiative is unlikely to be successful in isolation. Although in its infancy, the Junior Doctor Wellbeing Steering Group provides a forum for individuals advocating the importance of wellbeing and is a much-needed positive step forward.

The aim of the steering group was to bring individuals together to enable collaborative working.



Hugo De La Peña Gomez

Organisation: Oxford University Hospitals NHS Foundation Trust

Grade: ST6

Specialty: Medical oncology

Mentor: Professor Andrew Protheroe

The chief registrar title gives you a direct line to the trust's chief executive, Board of Directors, senior management and the president of the RCP in order to discuss ideas, drive change and achieve your goals. It gives you authority and allows/empowers you to embark on those projects you always felt were required/needed, but too busy to fully commit. The chief registrar title immediately opens doors. You will find how quickly people respond to your queries from now on.

Stratified follow-up pathways for cancer patients

Aim: To solve the urgent and almost universal problem of overstretched/overbooked clinics by avoiding having patients on waiting lists, which can compromise patient care, safety and experience.

Following on the success of a previous quality improvement (QI) project where we saved the trust £2.3 million over 5 years by simplifying the way we follow up our patients, we decided to stratify the follow up of germ cell cancer patients further.

On the new stratified follow-up pathway, each patient avoids 10 to 13 clinic appointments without compromising care or safety. This reduces personal cost by reducing travel and time off work, and reduces anxiety and stress associated with travelling to the hospital and parking.

We also saved on penalties for having patients on waiting lists and avoided paying locums for extra clinics. We therefore predict that this model will be shortly adopted and implemented to the wider supra regional network and other tumour sites at Oxford University Hospital NHS Foundation Trust.

On the new stratified follow-up pathway, each patient avoids 10 to 13 clinic appointments without compromising care or safety.



Andrew Deacon

Organisation: Royal Blackburn Hospital, East Lancashire Health Trust

Grade: ST6

Specialty: Respiratory medicine and general internal medicine

Mentor: Dr Shenaz Ramtoola

I have been fortunate to work with senior clinicians and allied health professionals all committed to a culture of quality improvement. Having close access to senior staff has provided a unique insight into the inner workings of the trust, and I have learnt immeasurably about my own leadership style and ability to communicate effectively. As the link between junior doctors and the senior clinicians some discussions have been challenging, but the training provided by the programme has allowed me to manage these situations in an effective manner, something that will only continue to grow and be useful into my consultant career.

Developing and sharing effective medical handover

Aim: To further develop an established medical handover system and educate others on how this could be implemented at other trusts.

Royal Blackburn Hospital has an established and effective medical handover, but it continues to grow and develop year on year. It has been praised by the Care Quality Commission (CQC) as well as by trainees past and present.

Two medical core trainees came to me with concerns regarding a lack of crash team role allocation and standardised post-cardiac arrest team debrief for our on-call teams. We undertook a pre-implementation survey of crash team members whereby 48% of responders explained feeling previously unsure about the names or roles of other crash team members at least 50% of the time, and 58% of people felt this impacted on patient care. This took several attempts to effectively incorporate into morning medical handover, but is now fully implemented and outcome results are awaited.

Several trusts have visited Royal Blackburn Hospital to learn from the medical handover, and we are working on a standardised way to develop it as a model elsewhere. As part of this I ran six well-received small group sessions on effective medical handover based upon the Royal Blackburn model at the 2019 RCP conference in Manchester.

Several trusts have visited Royal Blackburn Hospital to learn from the medical handover, and we are working on a standardised way to develop it as a model elsewhere.



Jonathan Dick

Organisation: St George's University Hospitals NHS Foundation Trust

Grade: ST5

Specialty: Renal medicine and general internal medicine

Mentors: Dr Richard Jennings and Dr Tim Planche

My year as chief registrar has been the most interesting and varied of my clinical career. The RCP development programme was a great resource that gave me insights both into my own personality as well as leadership strategies for different situations. I found the network of chief registrars a great asset, both in terms of hearing experiences from other hospitals as well as having a group of people to bounce ideas off.

Pathology demand management

Aim: To reduce wastage by targeting unnecessary or over-frequent pathology testing.

A sizeable proportion of pathology spend is incurred by unnecessary investigations. We aimed to achieve cost savings without any detrimental effect on patient care by identifying tests that were requested unnecessarily or too frequently.

We used mapping of pathology spend by test and department to identify potential areas of rationalisation. We compared patterns of ordering with existing clinical guidelines. In some areas this would require changes in ordering practices / clinical pathways, in others electronic decision support was needed to flag when tests were being ordered too frequently.

Examples of tests we identified that testing might be able to be rationalised included HbA_{1c}, brain natriuretic peptide (BNP), methicillin-resistant *Staphylococcus aureus* (MRSA) screening and routine coagulation screening. Annual recurring savings potentially achievable were in excess of £150,000.

The next step was to engage with departments, and to understand why, in some cases, these variances were warranted, but also to try and help them develop their own quality improvement programmes by which some of these potential inefficiencies might be addressed.

In order to support these efforts an electronic ordering support tool is being developed to highlight areas where test optimisation could be achieved. The next step is to roll-out the completed decision support tool to ensure sustainability of this programme.

Annual recurring savings potentially achievable were in excess of £150,000.



Roisin Dunwoody

Organisation: Kings College Hospital, London

Grade: ST5

Specialty: Respiratory medicine

Mentor: Dr Caroline Elston

Throughout training, I have often had ideas or projects that I have wanted to become involved in, but one of the biggest barriers is having the time and opportunity. The chief registrar programme provides you with just that: time and opportunity. The training provided from the RCP is invaluable and the community of other chief registrars allows you to meet others and learn from their experiences too. I went on maternity leave during my time in post, yet despite this, I found the time I did have was invaluable.

Improving out-of-hours communication

Aim: To improve out-of-hours communication between junior doctors and other members of staff, helping to improve safety and junior doctor workload and morale.

On arrival in post I was the first chief registrar that had worked in the trust. This was a daunting, but exciting, experience. I was able to design and develop my own project, focusing on areas that needed change. I was also able to work with senior clinicians and management, learning more about how things work at a higher level in a trust and become involved in teaching and training.

Kings College Hospital is a large tertiary trust with an incredibly busy out-of-hours workload. The nights and weekends are well-staffed, yet despite that its junior doctors often felt they had a very high workload exacerbated by frequent bleeps, making it hard to prioritise work. Speaking to nurses, they too found doctors struggled to answer bleeps promptly.

To start I conducted surveys of junior doctors and nurses for opinions on out-of-hours working. I also collected numerical and location data on the bleeps being received over a defined period of time. I also looked at serious incidents where communication among staff had played a role.

A solution for change I thought of was introducing an electronic jobs allocation system. Buying a ready-made new system would cost a lot of money, so with the help from the head of our trust's operating system (EPR), we designed our own system. We consulted with senior clinicians and management and hospital at night to design a system that would suit all.

The system provides a way of allocating and communicating jobs between nurses and doctors without bleeps, helping doctors to prioritise work and freeing up the bleep system for only urgent scenarios.

The project also highlighted that simple changes needed to be made, including re-allocation of bleeps, education on who carries which bleep and creating baton bleeps for out-of-hours work.

My work is still ongoing with staff training on how to use the new system occurring, with the roll out due very soon.



Kate Edwards

Organisation: Aneurin Bevan University Health Board

Grade: ST5

Specialty: Gastroenterology and general internal medicine

Mentor: Dr Deborah Wales

Allocating 2 days a week to the role as chief registrar has allowed time to build relationships with a range of colleagues which is a key aspect to delivering meaningful change. Through a combination of the RCP development programme and hands-on day-to-day experience I have enhanced my skills as a leader. The chief registrar scheme is a unique opportunity that gives you time and access to develop the skills, knowledge and understanding of how to successfully lead a team, to develop services and influence change within a complex management system, thereby creating confident clinical leaders of the future.

MISSING: Outlying medical patients. If found please bleep the medics

Aim: The aim of the project was to design new systems of working within the hospital to reduce the number of patients missed on the post-take ward round (PTWR) which is a vital stage in the admission process.

Initial data collection revealed that eight patients were not seen on the subsequent PTWR after admission. Reasons for this included patient details not being documented in the PTWR file by the admitting doctor, and delays in electronically updating patient location when transferred to outlying wards.

In response to this, a new electronic 'watch list' was created within the clinical IT system, Clinical Work Station (CWS) to improve documentation of patients awaiting PTWR. This was initially trialled for 24 hours within the medical intake; a subsequent online survey generated very positive feedback whereby 100% of staff stated the watch list was user-friendly and accessible throughout the hospital. However, the pilot study identified lack of IT facilities to allow an effective electronic handover, plus patients were still being transferred out of hours without 'real time' location updates.

Subsequently, IT facilities within the handover room were upgraded, and the bed management team took responsibility in updating patient location after transfers. Following implementation of the electronic watch list to the medical take, a further survey recorded that over 90% of junior medical staff felt the new system was an improvement on the paper list and 79% juniors found the electronic list easy to use.

The new systems of working have received criticism from a minority of consultant physicians for being a failure of the project aims. This has since been counterchallenged by further data showing zero patients were missed within outlying wards with the current systems in place. While this is an ongoing project, data so far has been positive and building on these changes over time is helping drive a culture of positive change for the hospital.

Over 90% of junior medical staff felt the new system was an improvement on the paper list.



Ruth Eyres

Organisation: Guy's and St Thomas' NHS Trust

Grade: ST5

Specialty: Geriatrics and general internal medicine

Mentors: Claire Mallinson and Maggie Hicklin

Becoming the chief registrar at a large, high-performing trust such as Guy's and St Thomas' Trust (GSTT) presents with its own challenges. With over 900 junior doctors at the trust spread over multiple sites, and departments that operate independently of each other, creating contacts and influencing change is challenging. The training programme helped me to understand my own leadership styles and empowered me to successfully influence those around me in ways I had not tried before.

Junior Doctor Experience: building on improvements into the future

Aim: To ensure that the junior doctor working conditions at GSTT are continually monitored and improved upon.

Continuing the work of the previous chief registrar, I have worked with the 'Junior Doctor Experience working group'. Created from the medical directors' office, we seek to improve working conditions for junior doctors. As a well-staffed, high-performing trust we are in a fortunate position to trial innovative ways to do this and have many invested senior leaders to call upon.

Previous improvements included 'Mess' redecoration, 'HALT' campaign and new rest facilities – a repeat survey was distributed to assess the impact of these. Engagement with the survey increased by 45% and the percentage of 'unsatisfied' or 'very unsatisfied' fell from 21% to 13% of responses.

Following this success, I am leading a new programme of work to address improvements suggested in the 2019 survey. These changes are separated into trust-wide, service-specific and educational-level projects. I have learnt

from my mentors how best to approach delegating service- and educational-level projects to their respective leads and suggested that junior doctors are involved in the change.

The trust-wide projects fall to the working group to tackle. It has been eye opening to be the first representative for junior doctors on some high-reaching, trust-level committees, and I have ensured the needs of junior doctors are included in discussions. We hope to see further improved survey results in 2020.

I provide a visible leadership link to all 900 junior doctors at the trust and am responsible for ensuring that junior doctors' needs are kept at the forefront of a large trust with many competing priorities.

I have ensured the needs of junior doctors are included in discussions.



Daniel Gatt

Organisation: Sheffield Teaching Hospitals NHS Foundation Trust

Grade: ST4

Specialty: Neurosurgery

Mentor: Jennifer Hill

The chief registrar programme has allowed me to look outwardly at the bigger picture. Rather than rethinking the whole system from the ground up, we can actively improve the existing framework to deliver the higher standards of care we are striving for. To list all of the skills that I have acquired from the programme in a few words is very difficult, however, what I can confidently say is that throughout the year I have been allowed the opportunity to observe many different types of leadership which will ultimately shape me into the leader that I want to become.

Refurbishment and relocation of doctors' mess facilities

Aim: To provide a high standard of easily accessible rest facilities to our junior doctors at both major sites in the trust.

During my year as chief registrar, I was expected to be the voice for juniors in an organisation that is large and widespread across our region. While many ideas were considered as to how I could contribute to improving junior doctor morale, modernising our outdated rest facilities seemed like the perfect one.

We faced many issues; first of all, within our main campus, the rest facility was located in a remote site which was hardly ever visited by anyone. Secondly, at our central campus, the rest facility was used as a rest area as well as a clinical area for handover. In addition to all of this, both sites had very outdated furnishings and fixtures.

In its infancy, the project seemed straightforward enough, however, as time elapsed it was evident that this was a large-scale project which required a lot of effort. Most of my time was consumed by compiling a feasible business case that proposed to relocate the main campus facility and repurpose the central campus facility. The business case was

presented to our trust investment team on two occasions and was even discussed at trust board level.

The venture allowed me to experience the ups and downs of healthcare design, frequently liaising with hospital architects and site surveyors. The large cost of the initiative (in excess of £300,000) meant really having to highlight the benefits of such a project as well as networking with the right teams of people to obtain multiple sources of funding.

The project should soon be taken over the line with works anticipated to commence in autumn 2019. If all goes to plan, we would have successfully created two safe spaces which would allow our trainee and consultant body to relax, debrief with their teams and ultimately make our trust a more desirable place to work.

The venture allowed me to experience the ups and downs of healthcare design.



Yee Yen Goh

Organisation: University College London Hospital

Grade: ST4

Specialty: Neurology

Mentor: Gill Gaskin

The programme gave me more insight into my own leadership style and taught me how to play to my strengths, and has given me practical tips on how to compensate elsewhere. It has also given me the opportunity to learn about engaging others in realising change to get the best possible outcome and making it sustainable. Most importantly, it has given me the self-confidence and language to communicate with trust management, which sounds trivial, but really isn't.

UCLH junior doctor intranet and NHNN intranet

Aim: Improve communication and engagement between the trust and junior doctors and improve transfer of institutional memory of workflows between junior doctor rotations.

University College London Hospital (UCLH) recently commissioned the development of a new mobile-enabled intranet site. With this, we were given the opportunity to develop a new junior doctor section as well as specific team sites.

Junior doctor intranet site

The main aim was to create a comprehensive online repository of information for UCLH junior doctors. To ensure that all relevant information was included, a team of junior doctors from across the trust were recruited to help with choosing content and design of the layout.

The new site includes information on clinical guidelines and employment affairs. Importantly, it includes information on junior doctor wellbeing, including information on trust-provided subscriptions to a mindfulness app, subsidised fitness facilities and cycle-to-work schemes. A discussion forum was created to enable junior doctors to share ideas and vote on improvement ideas, social affairs or sustainability.

National Hospital for Neurology and Neurosurgery intranet site

The National Hospital for Neurology and Neurosurgery (NHNN) is the UK's largest dedicated hospital to neurology and neurosurgery. As such, there are several hospital and specialty-specific workflows unique to the NHNN. Transfer of this information is often poor with junior doctor rotations, and this mobile app-enabled site allows us to keep this information up to date and easily accessible while in the clinical setting. This site includes information on local education opportunities, useful contact details, as well as clinical information on frequently encountered admissions.

Following launch in mid-July, the next steps are promoting use and engagement with the site, as well as ongoing improvement based on feedback.



Stanislav Hadjivassilev

Organisation: East Sussex Healthcare NHS Trust

Grade: ST6

Specialty: Cardiology and general internal medicine

Mentors: Dr S Merritt and Professor N Patel

The chief registrar role has been an incredibly rewarding experience. It has allowed me to mentor and represent trainees while immersing myself in quality improvement with the help and support from senior leaders. The RCP training days were very valuable in helping equip me with the tools needed for the job from influencing styles to information gathering and data interpretation. Meeting with and engaging with fellow chief registrars has also been a true highlight as we tackle common challenges in our respective healthcare environments.

Boosting weekend discharges: A WeekEnds@Home campaign

Aim: To enable a safe and effective weekend discharge and to boost overall weekend discharges.

Despite a 7-day working week, weekends still see the least number of patient discharges at East Sussex Healthcare Trust (ESHT). Only 8% of patients were discharged on a weekend across a 6-month period across both acute sites at ESHT. To try and address this we launched the WeekEnds@Home campaign to help boost our weekend discharges.

The aim of the WeekEnds@Home campaign is to highlight and increase awareness of the different options and support services available to enable a safe and effective weekend discharge and to boost overall weekend discharges, while also highlighting the dangers of unnecessary hospital stay.

We piloted four acute wards and created posters and flyers to help raise awareness of the different support services available to help facilitate a weekend discharge from social support services such as crisis response to therapies teams such rapid assessment and discharge. We further used the campaign to highlight the dangers of prolonged and unnecessary hospital stay.

In addition, we created a dedicated electronic weekend discharge list to be utilised by the weekend discharge doctor in collaboration with the pharmacy to help improve readiness for a weekend discharge. WeekEnds@Home ward champions were also assigned on a voluntary basis to help sustain the campaign.

Although the campaign is still in progress at time of publication, it has thus far been well received with minimal costs incurred. It has highlighted some of the challenges and complexities involved in weekend discharges and the need to allocate more resource to this area. We hope to achieve a full trust roll-out by the end of the summer with an overall primary target of improving our weekend discharges by 25%.

While 7-day services continue to improve we need not only a service improvement but also a culture shift in working practices when it comes to weekend discharges.



Phil Harvey

Organisation: Sandwell and West Birmingham Hospitals

Grade: ST5

Specialty: Gastroenterology and general internal medicine

Mentor: Dr N Trudgill

As frontline clinicians, we see the challenges with the way that our current system delivers healthcare. Many of these problems are most visible to those of us providing care in the middle of the night or on a busy Sunday afternoon. The scheme equipped me with insight into my own leadership style, taught me quality improvement methodology and gave me dedicated time to try to address some of these issues. As a chief registrar, I used the influence associated with the role in combination with 'Sunday afternoon' insight to try to effect meaningful change.

Wellbeing for junior doctors

Co-authors: Mike Blabber, Anna Lock, Huma Naqvi and Angela Holden

Aim: To reduce burnout among junior doctors and to help them recognise how to build a culture that supports wellbeing.

Wellbeing among junior doctors is challenging nationwide. Several factors have been attributed to this, including; the contract dispute in 2016, loss of the traditional 'medical firm' and not feeling valued by employers. Increased work pressures can leave junior doctors feeling isolated.

In parallel with other initiatives at the trust we ran a pilot of three sessions in an attempt to promote wellbeing in the core medical training (CMT) cohort. They were based on the theory of subjective wellbeing by Brown *et al* among others. Our intention was to create a supportive environment designed to promote self-awareness, self-care and a greater sense of 'togetherness' within the group. Each session lasted for an afternoon, including a short presentation followed by group discussions facilitated by interested consultants and specialty and associate specialist (SAS) and specialist registrars (StRs).

Feedback was universally positive. All respondents found the sessions to be positive and engaging.

Comments included:

- > 'really great session – more please'
- > 'good to think about patterns of thinking'
- > 'useful and helpful for our mental health'.

Burnout data was collected using the Maslach inventory and self-reported global ratings. At baseline 61.1% reported burnout, including 16.7% categorised in the highest band. By comparison, after the second session (4 months later) 18.2% reported burnout including 9.1% in the highest band. This suggests that although those with extremely high levels of burnout may not respond to sessions such as these, those with lower levels of burnout can.

On the basis of this feedback a business case has now been submitted to create a 1 day per week role at the trust. This will allow continuation and expansion of the content to other groups of trainee doctors and potentially to wider multidisciplinary team members.

Feedback was universally positive.



Rhiannon Hughes

Organisation: North Bristol NHS Trust

Grade: ST5

Specialty: Acute medicine

Mentor: Dr Kiaran Flanagan

The chief registrar programme has given me the opportunity to work as part of the medical management team, in a unique position as an advocate and voice for trainee doctors, with the aim of benefiting the whole medical division. The role with dedicated time and leadership training, alongside the experience of being a medical registrar, enabled me to identify and solve problems. Through this invaluable experience I now have a much better understanding of NHS leadership and management, and how to affect positive change.

Medical workforce project

Aim: To make multiple medical workforce improvements.

The aims of this project were to improve on-call working practices regarding staffing and management; improve engagement between medical registrars and the medical division; model current medical establishment against the RCP safe staffing benchmark; and reduce rota gaps and improve ward staffing through recruiting to 'new clinical fellow' posts with increased flexibility and development opportunities, and using an enhanced recruitment strategy.

Initially my work involved a series of changes to address issues with on-call working including undertaking projects to improve handover, ward cover, rota gaps, and communication between the medical staffing coordinators, medical divisional lead and doctors on call. Through listening to feedback, and engaging junior doctors, I was able to implement protocols which have improved our on-call processes. Starting regular meetings between the medical divisional management and the medical registrars opened an avenue for engagement and shared problem-solving which has been very productive.

Working with an internal analyst I created a model based on the RCP safe staffing guidelines, to give the division a better understanding of staffing distribution, specific to our trust, and with detailed inclusions of training requirements. I presented this to the division and it subsequently informed future workforce strategy.

The biggest achievement was the 'new clinical fellow' post element of the project. This required working within the trusts workforce teams to redesign and gain approval for new posts, for which I then developed an advertising strategy. I have increased the filled post rate from 25% to 100%. This will deliver a significant reduction in reliance on locums, and benefit the trust through increased continuity and additional quality improvement outputs. The trainees will be supported with increased staffing on the wards and on-call shifts, which should translate into increased training opportunities. The potential cost saving estimated by division is £300,000 for the year.



Chris Huntley

Organisation: Royal Wolverhampton NHS Trust

Grade: ST5

Specialty: Respiratory medicine

Mentors: Dr L Dowson and Dr K Sandhu

I have found my year as chief registrar highly enjoyable, educational and rewarding. It has provided me with time to lead and supervise a variety of quality improvement (QI) projects, including the development of a QI service, improving sepsis inpatient identification and management, and improving community-acquired pneumonia outcomes. I have also gained insight and experience in a variety of aspects of hospital management, including service development and business case writing, patient safety and incident investigations, mentorship and improving staff wellbeing and safety.

Laying the foundations of quality improvement

Aim: To improve the engagement with, number of and standard of QI projects undertaken within the Royal Wolverhampton NHS Trust.

The benefit of QI in the NHS is widely acknowledged and embedded within medical curricula. However, disparity remains between idealistic QI practice and local trust realities. As chief registrar, I identified the infancy of QI within our trust, with variable and inconsistent practice demonstrated. In response, I developed and delivered an initial QI Strategy, focused on four key elements.

Education

I wrote and piloted a four-workshop QI programme, training 127 F1, F2 and core medical training (CMT) doctors undertaking 27 projects. Workshops were interactive, supplementing each QI step (eg planning, doing, interpreting) with medical leadership training (eg conflict resolution, resistance to change).

Support and supervision

Success of the pilot programme resulted in workshop standardisation and delivery trust-wide to other staff groups (including consultants, managers and allied healthcare professionals).

Supplementary QI drop-in sessions provided individual teams with additional one-to-one QI coaching.

Governance and infrastructure

Formation of a medical division QI working group, composed of 10 key stakeholders, and review of the QI governance structure, including digital support, registration platforms and reporting.

Sharing learning

An inaugural QI showcase event provided a platform where the 27 QI teams could present their work, both inspiring and engaging the wider trust with QI principles.

The above four principles have demonstrated improvements in trust QI culture, staff empowerment, confidence to lead QI and staff leadership skills. As a result, the recently established trust continuous QI team will continue to build upon these foundations, with future work focused on electronic resources, training delivery, QI specialist development and sponsorship of select projects.



Shazia Hussain

Organisation: Barts Health NHS Trust

Grade: ST6

Specialty: Endocrinology

Mentors: Professor WM Drake, Dr E Rowland and Dr M Westwood

Being a chief registrar has given me the immensely satisfying opportunity to work with senior colleagues to identify ways in which we can not only enhance patient care but also work on ways to improve the working environment of doctors who deliver it. Attending regular training sessions as part of the development programme has allowed me to share my experiences with colleagues and also get useful tips on how to overcome challenges.

Hot cases: Improving general medical training in a tertiary centre

Aim: To improve general medical teaching and junior doctor morale in a tertiary centre.

Sharing clinical experiences is a fantastic way to simultaneously educate doctors, create a collaborative working environment, improve morale and ultimately ensure the delivery of high-quality patient care.

Generating a culture within hospitals that recognises the importance of training junior colleagues is paramount in inspiring the medical workforce. While many teaching events take place within specialist departments and as part of mandatory curriculum requirements, there aren't many opportunities for clinicians of different grades from multiple specialties to sit and learn together.

Over the course of this year I have successfully managed to set up an educational programme called 'Hot cases' which aimed at doing just that. Although directed at undifferentiated medical trainees the sessions have also been attended by physician associates, advanced care practitioners and medical students, highlighting the reach of such events.

Although support from an experienced panel of doctors passionate about general medicine is invaluable, I prefer to see 'Hot cases' as an educational lunch break where hospital staff discuss clinical cases and learn from each other in a safe environment. Through collating regular feedback from the growing number of attendees and sharing this with senior colleagues, 'Hot cases' has established a real following from junior and senior workers within the organisation which even helped me negotiate an in-house catering budget for regular pizza!

Undoubtedly, the success of this unique and exciting teaching event could only have been achieved through guidance from the leadership programme, encouragement from my mentors and support from the local medical education team.

Rota redesign
Engagement
Acute care
Working
groups
Education
Simulation
Intranet
Medical
workforce
Engagement
Follow up
Acute care
Education
Working groups
Communication
Sustainability
Sustainability
Doctors' mess
Simulation
Infrastructure
Medical
workforce
Electronic discharge
Collaboration
Leadership
Intranet
Follow up
Intranet

Electronic patient records
Frailty assessments
Quality improvement
Wellbeing
Medical outliers
Schwartz Rounds
Sharing of learning
Doctors' mess
Induction
Weekend discharge
Reducing burnout
Induction
Future healthcare
Engagement
Patient flow
Electronic patient records
Intranet
Communication
Schwartz Rounds
Quality improvement
Leadership
Intranet
Working groups
Induction
Follow up
Education
Rota redesign



Sushuma Kalidindi

Organisation: University Hospital North Midlands Trust

Grade: ST7

Specialty: Diabetes and endocrinology

Mentor: Dr J Oxtoby

This post has not only opened my eyes to the ‘management’ aspect but has taught me so much of my own ability. It opened so many doors and allowed me to gain skills on delegation, supervision, networking, mentorship, leadership and organisation. It allows you to see the ‘bigger picture’ in the NHS and that there needs to be a compromise between different areas to be a good team. Due to the excellent support that the programme has offered I was able to achieve challenges that I didn’t think I could do.

Junior Doctors Forum: Can they be improved?

To improve staff morale

As my aim was to improve staff morale, I volunteered to lead the Junior Doctors Forum.

1st forum: Using networking I managed to increase the attendance, however following feedback, I had realised it still needed improvement and set out to change this. Previous format was mainly an open floor discussion which didn’t yield much information as managers weren’t aware of the issues till the forum. Their response used to be ‘we need to look into this’.

2nd forum: An agenda was formalised, and trainees were encouraged to submit any issues beforehand, so that both myself (from a trainee point of view) and the trust could investigate. Trainee and managerial attendance increased dramatically, as both sides felt that there was constructive discussion happening at the forum which was being communicated back to trainees. A Whatsapp group of all trainee representatives was set up so issues can be highlighted quickly and escalated.

Further forums: With each forum we were able

to make changes including setting up ‘internal departmental forums’ so that the main junior doctors forum was equally represented by all specialities and that one speciality didn’t take over.

Using issues raised at the forum, I was able to make changes such as introducing a ‘Clerking booklet in medicine’, revamping rotas to achieve continuity on wards and better work life balance and improving rota gaps. In addition, this post has allowed me to do projects on ‘Expediting discharges’, ‘Readmission audit’, Getting It Right First Time (GIRFT) and helping set up a ‘core medical training (CMT) procedural skills training day’.



Francis Kynaston-Pearson

Organisation: Nottingham University Hospitals Trust

Grade: ST7

Specialty: Rheumatology and general internal medicine

Mentor: Dr Mark Simmonds

The past year of training has been my most valued training year to date. The key ingredients have been the time and freedom to pursue projects closest to my heart, and the senior support and job title that have empowered me to deliver on them. From developing the skills to help in future service development, to the personal and professional growth into someone better equipped to take on a consultant role, I feel the chief registrar role has been an invaluable experience, and has provided me with a network of inspirational colleagues and a renewed sense of optimism for the future.

Improving the trainee experience

Aim: To improve the experience of junior doctors working at Nottingham University Hospitals Trust (NUH) and celebrate their contribution to the organisation.

I have focused my efforts and projects as chief registrar into three key themes.

1. Making the best first impression

- > Working with a task and finish group to redesign the trust induction:
 - less emails from fewer sources
 - a welcome cover letter to new trainees
 - a more streamlined induction process.
- > Production of a new doctor reference handbook for 'all things NUH'.
- > Completion of a multi-cycle quality improvement programme developing new ward guides and induction videos ('doctors voices') now being rolled out across the trust.

2. Facilitating transition

- > Establishing what constitutes 'key' equipment across the trust using surveys from over 100 doctors and comparing this to current provisions on the ward has led to:
 - a submission for funds for doctors on-call bags for out-of-hours shifts that contain key equipment
 - working with the divisional nursing team to standardise the layout of equipment and stationery and doctors' use across the trust.

- > Working to produce grouped email lists to simplify and improve targeted communication to trainees (eg sending an email to 'all core medical training (CMT) doctors').
- > Keeping NUH doctors up to date with my work and ongoing trust developments with monthly 'Chief's Brief' emails.

3. Celebrating success

- > Delivering a conference to over 100 trainees.
- > Four 90-minute educational seminars on key themes of:
 - supporting you
 - enhancing your career
 - patients first
 - beyond medicine.
- > Thirty-five abstracts being showcased.
- > Morning and afternoon keynote addresses.
- > Sixty delegates attending a 90-minute clinical skills workshop.
- > Closing awards ceremony celebrating outstanding individuals.

The NHS workforce is its most valued asset and it has been a real privilege over the past year to be gifted time and given support to try and improve the experience of my hardworking colleagues at NUH.



Amanda Laird

Organisation: Portsmouth Hospitals NHS Foundation Trust

Grade: ST6

Specialty: Nephrology and general internal medicine

Mentor: Dr L Knighton

The chief registrar role is now an established link between senior management and the junior doctor workforce in my trust, providing me with the opportunity to be involved in service development at a wider trust level and also facilitate projects inspired by junior doctors themselves. The formal leadership and management training has provided both personal and professional development, equipping me with the skills to lead more effectively and influence positive change. On reflection, this year has been full of challenges but deep personal reward, and it has been a privilege to be part of the programme.

Always improving

Aim: Improving junior doctor morale through increasing educational opportunities and formal feedback.

The main focus of this year was to seek to improve junior doctor (JD) wellbeing and morale, and also highlight the trust's focus on patient safety.

A monthly JD forum allows open access for any JD to bring any issues or concerns directly to myself and the medical director. From these meetings directly or indirectly, several educational issues were highlighted which I sought to address:

- > change to the medical registrar rota to allow attendance at the post-take ward round (PTWR), maximising educational opportunities and safer handover of sick patients
- > introduction of a peer-led medical registrar procedures course to maintain procedural skills
- > simulation training for medical registrars on the cardiac arrest team to improve leadership skills and explore human factor influences during the emergency scenario.

To improve morale amongst JDs, annual awards were instigated to recognise the hard work and achievements made by a workforce that is normally rotational and often not recognised in this way. There were over 230 nominations for 150 doctors, and each received a certificate of nomination. This had universal positive feedback from juniors who appreciated the positive feedback.

Highlighting the trust's focus on patient safety, I continued the 'Lessons Learnt' programme among the foundation year doctors, developing this further by producing 'watch out' posters for each patient safety incident presented for trust-wide learning. The aim is to also introduce this into the new IM3 teaching curriculum.

I also helped organise a 'Patient safety' conference for the trust facilitating JDs to present their quality improvement projects for trust-wide shared learning.

The valuable role and unique insight of JDs means they must be engaged in frontline service development and the chief registrar role has allowed me to facilitate this engagement.



Jayne Little

Organisation: Manchester University NHS Foundation Trust

Grade: ST6

Specialty: Rheumatology

Mentor: Sally Briggs

The chief registrar programme has given me the time, space and understanding to lead complex and lengthy projects that would have been challenging to undertake in a full-time clinical job. The national network of chief registrars and relationships built within the RCP have proven invaluable, and the formal position within my hospital and trust has opened many doors. I come away from the scheme with an understanding of NHS management that I believe could have taken years to acquire as a consultant, and a deeper and realistic understanding of service development and workforce challenges.

Novel recruitment of medical junior doctors

Aim: To reduce rota gaps and locum spend on junior doctors within the division of medicine.

In recent years, there has been a significant cultural change around career planning amongst junior doctors, with fewer progressing directly onto further training every year. This has significant implications for workforce planning on national and local levels. Rota gaps within the division of medicine at Wythenshawe Hospital led to total junior doctor locum spend of >£1.1 million in the last financial year.

The results of a scoping exercise I conducted amongst current foundation year 2 doctors (FY2s) in the hospital offered hope. When asked about their plans for the following year, although 46.7% intended to spend time travelling or working abroad, 73.3% would be attracted to apply for a substantive post that allowed dedicated time away from clinical work to develop professional or specialist skills.

We have appointed 29 non-training grade doctors to the division for 12-month substantive placements from August 2019. A novel fellowship scheme will allow the doctors one 'development day' per week to

undertake quality improvement, education or research projects, or to develop specialist skills/experience. The calibre of the 19 doctors appointed in the first round was so high that the scheme was expanded to its current number. The scheme has estimated savings of £644,000 per annum.

The value of the scheme is not purely financial, bringing the benefits of a committed, skilled and consistent workforce. Investment in these juniors through the 'development days' sends a clear message that we value our staff and the productivity of these days will impact on service and workforce development. This scheme offers a sustainable solution to workforce issues in a time of change.

The value of the scheme is not purely financial, bringing the benefits of a committed, skilled and consistent workforce.



Elizabeth Lonsdale-Eccles

Organisation: Great Western Hospital, Swindon

Grade: ST5

Specialty: Geriatrics and general internal medicine

Mentor: Carolyn Mackinlay

The chief registrar year has been a great opportunity for personal development and self-reflection. I have been supported to learn about my own personality strengths and weaknesses, and preferred leadership styles. This has also allowed me to better relate to and understand the perspective of others. Working across teams in a large organisation and having the opportunity to develop my negotiation and interpersonal skills has been incredibly valuable.

Medical outliers

Aim: To improve the quality of care and workforce experience for medical outliers.

I worked in collaboration with my fellow chief registrar on a large project aimed at improving the quality of care and workforce experience relating to medical outliers. We used Kotter's '8-Step Process for Leading Change' as a model for our project.

The initial tasks of creating a sense of urgency, building a guiding coalition and forming a strategic vision were achieved early on. There was already awareness among clinicians of the significance of the issues in terms of the volume of patients, quality of care and resource limitation. A working group consisting of senior clinical and non-clinical leaders was established, with the task of improving and supporting the process through the upcoming winter months.

There were early wins such as instituting a robust handover process, bolstering the medical staffing numbers and improving continuity and communication which improved patient safety in the short term. As the year progressed and we were able to gather more data to fully understand the scale and breadth of the issues involved, we had uncovered a wicked problem.

Moving forward with sustained acceleration to institute long-term change has involved engaging senior leaders at the highest level. Our subsequent focus has shifted from short- to long-term plans to ensure improved care for medical outlying patients into the future. We are continuing to work with the trust to establish a sustainable and effective model of care which is safer for patients, appropriate for staff, and takes into account the changeable clinical environment.

Instituting a robust handover process, bolstering the medical staffing numbers and improving continuity and communication which improved patient safety in the short term.



Akish Luintel

Organisation: University College London
Hospital NHS Foundation Trust

Grade: ST5

Specialty: Infectious diseases and acute internal medicine

Mentor: Professor Marcel Levi

The chief registrar scheme has helped me better understand how a hospital works, and how to implement change and create a voice for junior doctors. The most valuable skills I have developed were to understand what each member of the organisation did, which allowed me to ask the right questions to the right people. I was extremely fortunate that I had a supportive CEO and department which gave me (almost) free reign about what projects I wanted to do but also to use my creativity to come up with new ideas. I was given the responsibility and freedom to lead projects in the trust.

Electronic health record system implementation

Aim: To smoothly design and implement our new electronic health records system.

Electronic health record system

University College London Hospital launched its new electronic health records system (EHRS) in April. I worked closely with the EHRS team to design parts of the system, helping with an electronic acute take, and managing patient lists and the output of discharge summaries.

Rapid flu testing

Alongside the EHRS, I worked on rapid flu testing, and created and implemented a point-of-care test in the emergency department to diagnose flu, which reduced turnaround times to 30 minutes.

Junior doctor wellbeing

I worked with my junior colleagues to audit workload on-call and presented to our local junior doctors' forum. We managed to secure funding for a further doctor to work from August. On top of this we have secured funding and planned our first summer party for junior doctors for years.

'Patients we do not see' video

We as a group of chief registrars are producing and creating a video looking at the impact of late discharge on patients we do not see directly and will be filming in late July for August induction.

Teaching

I worked to reinstate practical assessment of clinical examination skills (PACES) teaching within the trust which now runs twice weekly. We are working with local hospitals to try and make this regional.

Environmental

The project I am most excited about is creating a group focused on the carbon footprint of the hospital. We have begun creating a sustainability group in the hospital and quality improvement projects with a green focus.

We are working with local hospitals to try and make this regional.



Danielle Lux

Organisation: Croydon University Hospital NHS Trust

Grade: ST5

Specialty: Neurology

Mentors: Dr Nnenna Osuji and Dr Karen Kee

The RCP modules and faculty have been an excellent resource complementing the practical aspects to steering and facilitating complex discussions. The leadership programme has given me an invaluable skill set, from learning about leadership styles, personality types and quality improvement project (QIP) methodology. I have grown in confidence and understanding of how to engage colleagues and encourage collaboration, including learning from difficult personalities and situations.

Hospital evolution in a digital age: Improving transparency, management and flow from the front door

Aim: Creation of an electronic referral system and task management tool to improve leadership and management of the acute medical take, improve resource and bed allocation, and facilitate single doctor clerking implementation.

My role as chief registrar has been challenging, not least as a non-acute medic 'impostor' at a trust in crisis, but also having never worked there before offers insights on what projects to tackle upfront. However it has been a unique and privileged opportunity to be exposed to and work closely with management and senior clinicians in understanding the complexity of change, as well as being integrated into various planning committees to find solutions for the everyday while focusing forward on the trust vision.

Croydon Hospital serves a large and deprived community. Croydon A&E Type 1 performance was worst in the UK with high aggregate patient delays. Emergency department capacity and function is impeded by delays in specialty review, decision-making and subsequent departure, compounded by staff vacancies.

Process-mapping evaluated the current closed referral system. Through shadowing shifts and staff surveys I learnt about work behaviours and experience and used working groups to co-design an aspirational process using an electronic tool. This allows clerking by care and flow whilst increasing transparency between the A&E, medicine and site teams, essential in facilitating single doctor clerking.

One of the most important benefits is the availability of real-time data to guide performance and map work volume to workforce, allowing prompt adjustment.

Engagement meetings with stakeholders for single clerking have been challenging; the process depends heavily on collaboration of A&E and medicine. After significant and complex delays, but with 100% engagement of the new electronic tool, we are now piloting this.

Preliminary results suggest reduced time to senior decision-making and more consistent work volume with less dramatic peak referral times. Greater registrar oversight and improved educational opportunities were reported.

The engagement talks have motivated junior doctors to become more involved in QIPs. One of the more rewarding and practical roles as chief registrar was in using what I have learnt to guide junior doctors on who to collaborate with. Through establishing a Junior Doctor Committee, I was able to disseminate two-way information on my initiatives, raise awareness of vacant shifts and provide support and guidance on potential QIPs.



Huda Mahmoud

Organisation: University Hospitals Derby and Burton

Grade: ST7

Specialty: Nephrology and general internal medicine

Mentor: Dr Chris Whale

It has been a privilege to be the first chief registrar at University Hospitals Derby and Burton (UHDB). It has been a challenging time for all, with the trust merger and unprecedented winter pressures. But with the support of the scheme, mentorship from my supervisor and the guidance of senior managers and clinicians, I have been able to concentrate on identifying and addressing the many demands faced by medical registrars at both sites in our trust. The knowledge and skills I have gained during this experience will undoubtedly continue to help me as a consultant to continue to improve patient care and working life for junior doctors.

Supporting the medical registrar workforce

Aim: To identify and address medical registrar training morale and workforce challenges across both hospital sites in the midst of new trust merger.

Similar to many trusts, UHDB faces registrar rota gaps and the subsequent effects on patient safety, staff morale and finances. These were addressed by developing a working group to streamline the way gaps are identified, prioritised, advertised and escalated, potentially saving 15% of annual internal locum spend. The combination of new cross-site medical registrar posts and a recruitment drive were implemented in order to tackle the gaps at Burton Hospital. Thus far, this has resulted in a reduction in length of stay by 0.5 days. From August 2019 it is expected that there will be a significant reduction in external locum reliance (currently ~70% of locum fill) and spend.

Medical registrar training concerns around exam attainment and procedural competence were addressed by holding the first mock practical assessment of clinical examination skills (PACES) exam and procedural skill sessions; 80% successfully achieved MRCP(UK) PACES. Furthermore all events received good/excellent feedback from participants and will continue to be part of UHDB's training programme.

Medical registrar forums were established to allow senior clinicians and managers to meet and discuss registrar concerns. Significant changes to working patterns have been implemented because of these meetings. One such intervention; urgent lumbar punctures are now no longer performed by the cardiac arrest bleep-holding registrar, therefore reducing interruptions during procedures and improving patient safety. When surveyed, 83% of medical registrars felt morale was good and 90% felt heard by management.

Finally, it was an honour to have won the first RCP Turner-Warwick prize, showcasing the above work and more on behalf of the collaboration of amazing colleagues at UHDB.

83% of medical registrars felt morale was good and 90% felt heard by management.



Scott Mather

Organisation: Manchester University NHS Foundation Trust

Grade: ST5

Specialty: Geriatric medicine and general internal medicine

Mentor: Dr Jon Simpson

My time as a chief registrar has been one of the most rewarding experiences of my career to date. Tackling challenges alongside learning how to navigate NHS systems has improved my ability to make lasting improvements. Applying techniques taught by the RCP leadership training programme has helped me to develop a range of skills including how to build a convincing case for change, facilitate discussion and apply robust quality improvement (QI) methodology for data measurement.

The development of the acute frailty team

Aim: To improve the care of patients living with frailty presenting at the emergency department by the implementation of frailty screening and development of a responsive multidisciplinary frailty team.

NHS Improvement (2018) recommends that all patients aged over 65 attending the emergency department (ED) should be screened for frailty, and all patients with frailty should have access to a team capable of assessing frailty syndromes. Initially a steering group was established to support the development of acute frailty services at Manchester Royal Infirmary. The group comprised of myself, consultant geriatricians and representatives from the ED, local care organisation, ambulance service, GPs, pharmacy, therapy and trust management.

An acute frailty team (AFT) was established in October 2018 offering 35 hours per week. Older patients (≥ 65) presenting to the ED with a clinical frailty score (CFS) of ≥ 4 were reviewed by the AFT if they did not meet the exclusion criteria (such as trauma, stroke or medical emergency). These patients then underwent a comprehensive geriatric assessment (CGA). The initial pilot ran until December 2018. A further pilot commenced in February 2019 including GPs working as part of the AFT with reduced consultant physician presence. This model provides 42.5 hours/week.

In total, 154 (phase 1) and 305 (phase 2, ongoing) patients have received a CGA by the team since the project commenced. Over 50% of patients were discharged directly from the ED or acute care unit.

Alongside this work, electronic frailty screening has been developed. An electronic screening tool was developed within the 'Patientrack' system however compliance remains poor at approximately 20–30%. We are currently progressing to mandatory CFS screening at ED triage.

As chief registrar, I have worked alongside the clinical director to lead this project and design new services. This has taught me the process of business case development.

I will continue to build on the knowledge and skills I have acquired in my remaining 2 years of training.



Greg Morris

Organisation: North Tees and Hartlepool Foundation Trust

Grade: ST5

Specialty: Acute medicine

Mentors: Dr Nick Roper and Professor Jane Metcalf

The chief registrar leadership training has helped me evaluate my own leadership style and identify strengths and areas that I needed to develop further. The peer support and coaching has been fantastic, and as a group we have helped each other develop our projects and overcome challenges. My trust have helped by giving me exposure to executive shadowing and invaluable mentoring. The role itself has opened a huge number of opportunities, including improving the hospital at night, implementing trials and working with NHS Improvement.

Improving weekend staffing

Aim: Improving out-of-hours staffing to decrease junior doctor workload and improve patient safety and flow.

In my trust junior doctors have struggled with their workload out of hours and workload intensity has been flagged on multiple deanery and General Medical Council (GMC) surveys. When junior doctors have been asked their concerns, they feel that they struggle to provide the care they want to at the weekend, and have difficulty managing the tasks asked of them.

My project has identified areas where medical staffing can be improved out of hours. By redesigning our rotas, and weekend staffing duties, we have increased our weekend ward cover in line with RCP guidance on safe medical staffing. With the new rota design, each ward will have its own doctor from 9am–5pm on Saturday and Sunday. We anticipate that this will decrease the workload on junior doctors out of hours and improve the experience for patients and nursing staff. As part of the changes, doctors working at F2, core training (CT) or vocational training scheme (VTS) level will no longer have to work any weekend with three consecutive long days, helping reduce fatigue.

The changes have begun in August 2019 as new doctors rotate to the trust. At the same time, out-of-hours consultant presence has been increased, allowing more senior reviews at the weekend. We anticipate this will increase the flow through the hospital and allow us to decrease the beds used for medical outliers. The cost savings from this will be allocated to hiring additional nurse practitioners to boost ward cover during the week.

When junior doctors have been asked their concerns, they feel that they struggle to provide the care they want to at the weekend, and have difficulty managing the tasks asked of them.



Shamim Nasrally

Organisation: University College London Hospital NHS Foundation Trust

Grade: ST7

Specialty: Acute internal medicine

Mentor: Professor Geoff Bellingan

The chief registrar scheme has helped me better understand how to influence and persuade others, especially those in decision-making positions. One of the most valuable skills I developed was stakeholder engagement and bringing together people with different agendas and perspectives. I was extremely fortunate to have been fully welcomed and integrated into the trust's management teams. I was given the responsibility to take on important projects for the trust, with adequate support, and within a governance framework that ensured scrutiny, challenge and support.

Electronic discharge summary redesign

Aim: To improve the quality and clarity of the new electronic discharge summaries produced by the trust.

Electronic health records system

University College London Hospital (UCLH) launched its new electronic health records system (EHRS) in early 2019. This system superseded multiple other clinical systems including the clinical documents system producing the electronic discharge summary. Initial feedback from primary and community care shortly after launch indicated that the new discharge summaries were lengthy, unclear and difficult to file.

I led a task and finish group which comprised of multiple stakeholders spanning specialty, discipline and professional groups. The group consisted of clinical staff, administrative staff and technical staff with the appropriate IT knowledge and skills. The issues raised from the feedback were addressed, and both the inpatient and emergency department discharge summaries were reviewed. Proposals to remove, amend or insert sections into the discharge summary were discussed among the group.

Proposals that emerged from the group were then tested with primary care and community clinicians before being taken to an internal governance structure for authorisation. The successful proposals were implemented as they were approved. The changes were fed back to primary and community care, and over time the improvements resulted in fewer feedback submissions focused on the discharge summaries.

These technical improvements were accompanied by an educational initiative to improve the clinical content of the discharge summaries. A survey is due to be sent to our primary care partners shortly to gauge their satisfaction with the new discharge summaries.

I led a task and finish group which comprised of multiple stakeholders spanning specialty, discipline and professional groups.



Chris Odedun

Organisation: Whipps Cross University Hospital,
Barts Health NHS Trust

Grade: ST6

Specialty: Emergency medicine

Mentor: Charlotte Hopkins

The parts of the RCP development days I found most useful were the ones focused on the first two segments of the Faculty of Medical Leadership and Management (FMLM) leadership standards: 'self' and 'team player'. The sessions were important building blocks for me to appraise my own strengths and weaknesses, and were very informative in reflecting on why some work relationships just 'work' and some require immense effort, sometimes to little avail. The action learning sets were really excellent – an opportunity to practise giving focused feedback and receiving it from peers.

What went (w)right at Whipps Cross emergency department?

Aim: To improve psychological safety by embedding 'Greatixes' into emergency department practice.

A 'Greatix' is an excellence report, an instance of staff feedback on high-standard care. Greatixes are underpinned by 'Safety-II' theory: recognising excellent care can improve psychological safety of staff, team morale and, ultimately, patient safety.

Having observed the benefits of these approaches elsewhere, I was keen to share this approach with the emergency department (ED) through my project 'What went (w)right at Whipps Cross emergency department,' otherwise known as W4xED. Central to it is a purpose-built online survey tool which allows us to collect Greatixes from any staff member about their colleague's work in the ED.

Over 8 months, W4xED has collected more than 130 Greatix submissions. Each Greatix is sent anonymously via email to the colleague who has demonstrated excellent care, and their line manager. After thematic analysis, submissions have been used in clinical governance and as part of new doctor inductions, demonstrating individual and team-based applications.

Anecdotal evidence from senior stakeholders and Greatix recipients suggests they have positively affected their morale. W4xED has become part of a trust-wide push to improve the working environment, and buy-in from the senior ED team has encouraged nurses and managers to join me in improving W4xED by using quality improvement methodology.

Leading on W4xED has taught me much about the importance of clear verbal and written communication, and the frequency of message repetition needed to create change. The RCP's action learning sets have been a great help in gaining feedback. The skills gained will all benefit me hugely as I move closer to certificate of completion of training (CCT) at the end of 2019.

Anecdotal evidence from senior stakeholders and Greatix recipients suggests they have positively affected their morale.



Panos Prevezanos

Organisation: Southern Health NHS Foundation Trust

Grade: ST6

Specialty: General adult psychiatry

Mentor: Dr Mayura Deshpande

The chief registrar programme offered me the opportunity to collaborate with our trust's clinical leadership and transformation team on a range of exciting projects. At the same time, it enabled me to develop a range of leadership and service improvement skills that will make me more effective in my upcoming consultant role. Most importantly, it widened my perspective of a senior doctors' role, by highlighting our responsibility to address the needs of not only individual patients but also the entire population supported by our service.

Portfolio of projects focusing on education, staff wellbeing, recruitment and retention

Aim: To improve education, staff wellbeing, recruitment and retention.

Rather than focus on a single project, I decided to take on a portfolio of projects. This allowed increased opportunities for learning as well as collaboration with a wide range of colleagues across the trust.

- > We explored psychiatric trainees' experience of serious incident investigations through a qualitative study. We utilised the outcomes to formulate trust guidance on how trainees could be supported through investigation processes in a way that protects their wellbeing and makes their involvement a meaningful learning experience.
- > We reviewed the trust induction and orientation period for clinical and administrative staff, utilising quantitative and qualitative approaches. We utilised the results to plan and introduce changes that will increase the support offered to new starters and offer them an improved experience.
- > We introduced a positive event reporting tool, to improve staff morale and allow improved learning from excellence. Following a well-received pilot programme, the tool is due to be rolled out to the entire trust.
- > We reviewed postgraduate training posts in psychiatry within the Wessex area and created an online map of posts to allow trainees more control of their training trajectories.
- > We introduced quality improvement teaching and mentorship for doctors in training.
- > > We organised a 2-day summer school to promote a career in psychiatry to local medical students and foundation programme doctors.

We introduced a positive event reporting tool, to improve staff morale and allow improved learning from excellence. Following a well-received pilot programme, the tool is due to be rolled out to the entire trust



Sam Raveney

Organisation: Epsom and St Helier Hospitals NHS Trust

Grade: ST6

Specialty: Palliative medicine

Mentor: Dr Vanessa Kahr

The chief registrar programme has vastly improved my awareness of how NHS hospital trusts are managed, structured and organised. I have been able to learn about the complexities of change management, and the difficulties and barriers related to this within a NHS hospital both from the RCP study days and from real life practice. Combining my clinical and non-clinical roles in a busy district general hospital has given me a very useful insight into the organisation and balancing act that consultants need to develop to deliver their roles as senior leaders.

Developing a directory of services for St Helier Hospital

Aim: Improve junior doctor ability to contact and make timely referrals by developing an electronic referral guide and directory of services.

I am the first RCP palliative medicine chief registrar, and the first chief registrar employed by my trust. This has meant a learning curve for all. I have gathered feedback from doctors at ward level and have used my role to bring about a holistic approach to airing and tackling these issues. I have not solved all the issues, but I have been able to help identify problems, and escalate these through various routes so that people who are in a position to enact change are aware of these.

My main project has been focused on the development of an electronic directory of services / referral guide. The lack of guidance about the services available and the processes for contacting them was one of the areas of frustrations voiced by junior doctors when I started at the trust. Initial feedback has been very encouraging but I have not finished data collection as yet.

I have also been involved with work improving induction and escalating issues related to morale/staffing, and concerns related to handover process and working patterns.

I am working to improve junior doctor involvement with governance, facilitating junior doctors being involved with incident reviews, serious incident panel, governance meetings and the mortality review process.

I have learnt so much from this programme, I wish I was starting my year all over again as there are things that I would do differently in retrospect. I have developed invaluable experience in change management and quality improvement methodology that I will take with me to future roles.

I have loved working across hospitals and specialties and working with non-clinical and clinical colleagues. Learning from the richness of everyone's unique experiences, and being in a position to help communicate issues both ways between senior management and the junior doctor clinical workforce has helped escalate and clarify issues and work being done to address them.



Elinor Shuttleworth

Organisation: Manchester University NHS Foundation Trust

Grade: ST7

Specialty: Gastroenterology

Mentor: Dr Leonard Ebah

The chief registrar programme has been a time of real challenge and personal growth. The training provided by the RCP has built my confidence in making and communicating the case for change. The role has opened doors, allowing me to work with senior colleagues within my trust and share front-line experience with them. The peer support and shared knowledge fostered by the programme was invaluable in building my resilience to see projects successfully through to completion.

Improving interspecialty communications

Aim: To streamline the patient journey by developing a new online multispecialty referral system.

In response to concerns around lost paper referrals and inefficiencies due to multiple referral pathways I led development of an online referral system for gastroenterology.

This reduced the time taken to communicate specialty advice from 10 minutes to less than 5 minutes per patient. One-hundred per cent of junior doctors preferred this to the previous system and all were in favour of roll out in other specialties. Three other medical specialties have adopted this system and more are in progress. The system provides a clear audit pathway, which has been instrumental in development of a consultant of the week working model within gastroenterology.

Other projects have included leading a project to improve responses to automated early warning score alerts, with the aim to streamline and relaunch the system in mid 2019, and development of a cross-trust trainee feedback forum.

One-hundred per cent of junior doctors preferred this to the previous system and all were in favour of roll out in other specialties.



Fang En Sin

Organisation: Royal Sussex County Hospital

Grade: ST7

Specialty: Rheumatology and general internal medicine

Mentor: Dr Sarah Doffman

This year has been invaluable. The chief registrar leadership development training has provided a useful framework around which to plan, implement and measure the impact of local change projects. The support network helped me develop ideas and acted as a source of support and encouragement. I am heartened that the positive impacts I have made as a chief registrar were acknowledged during a Health Education England (HEE) visit, and I hope to continue working on improving the working lives of doctors and our colleagues in my future career.

Understanding and addressing medical workforce challenges in a large university teaching NHS trust. Is the answer always more, harder, faster or simply smarter?

Aim: To benchmark local workforce and workload against RCP standards, identify root causes for workload and workforce variation between medical teams and suggest actions to help future-proof the workforce.

A review of the workforce was needed to address mismatch in workforce alignment across different medical teams across the trust, following a major reconfiguration of the consultant workforce to keep in pace with current patient demographics and demands. In addition, we also recognised that workforce imbalance contributes to several red flags in the General Medical Council trainees' survey and low morale of junior doctors (JDs). I worked with my fellow chief registrar and led two core medical training colleagues in carrying out this project.

The activity of 20 medical teams across the trust was audited, applying the RCP toolkit to estimate workload against recommended workforce. Root causes of variations and potential solutions were identified through discussion with stakeholders.

We found a wide variation in workload to workforce ratio between teams, which matched JD's feedback and exception reporting data. Pre-registrar level staffing was above RCP recommendations in all teams, while registrar-level ward presence was grossly inadequate.

The findings were presented to the medical director and stakeholders including JDs, and 19 agreed interventions were finalised. Prioritised interventions included:

- > Amend registrar rota to improve availability to ward teams (completed).
- > JD-led and IT-led workstreams to 'lean up' inefficient clinical processes and improve electronic systems/ access (in progress).
- > Review of workforce composition including consideration of cost-neutral solutions such as physician associates (in progress).

The project will not be completed in whole during my time as a chief registrar, but I am glad this has been recognised at directorate levels and actions are in place to take things forward.

Along the way, I have also picked up on various issues related to JD working lives which I have been able to improve on through smaller quality improvement projects, such as standardising out-of-hours bleeps and roles, and improving the medical handovers. Knowing that their challenges are being addressed seriously has in itself boosted the morale of JDs in the trust.



Clare Smith

Organisation: University Hospital Southampton

Grade: ST5

Specialty: Paediatrics

Mentor: Iain Simpson

The chief registrar leadership development programme provided me with a toolkit to use throughout the challenging aspects of the chief registrar role. There is immense value in the diverse network of people on the programme that shape ideas and provide contrasts and constructive challenge within a safe environment. I have learnt through trying and practical real time application of theory and processes, excelling my personal and professional development.

Improving discharge summaries at University Hospital Southampton

Aim: Over 12 months (September 2018–19) to improve discharge summaries across the trust by: reducing the time to complete by 30% and improving end-user satisfaction.

I used the Institute for Healthcare Improvement (IHI) Model for Improvement to frame this piece of work. Background work identified three key stakeholders – patients, GPs and University Hospital Southampton (UHS) staff. For patients we reviewed complaints and calls to the medicine information helpline, ran focus groups and completed a survey. Fifty per cent of patients felt the quality of the discharge summary was average to very poor.

GPs locally are employing people to decipher the information within a discharge summary. It takes an average of 24 minutes for a junior doctor to complete a discharge summary and one in four times the computer system crashes. I led a team across the hospital including internal and external stakeholders across sectors and multidisciplinary teams (MDTs). I led negotiations with commissioners to ensure local applicability of nationally mandated content, which was written into the UHS contract (April 2019).

Engaging with stakeholders locally we identified ‘the want’ and ‘the need’. We have produced a discharge summary that is half the length, and will take one third less time to complete.

We presented the changes to over 300 people and there was ‘standing room only’. We are now taking it through the required governance steps with final sign off anticipated in July 2019.

We have demonstrated that by reducing the time to complete by one third, we will release six whole time equivalent (WTE) junior doctors every year. We currently have, on average, 51 lost bed days a month due to discharge summaries not being completed on time. This equates to £152,000 of activity each year and has a significant impact on flow of information

We have demonstrated that by reducing the time to complete by one third, we will release six whole time equivalent (WTE) junior doctors every year.



Iain Smith

Organisation: Gloucestershire Hospitals NHS Foundation Trust

Grade: ST7

Specialty: Renal

Mentor: Alex D'Agapayeff

Having the time to pursue improvement projects and reflect on myself as a leader has been invaluable to develop the skills needed to succeed as a consultant. The chief registrar role has opened doors in my trust to give me access to people and resources I would not have otherwise have used, and given me a deeper understanding of the management structures within the trust and how to negotiate them successfully.

Improving inpatient phlebotomy services

Aim: To improve the efficiency of inpatient phlebotomy services to speed up discharges through the day.

I brought together a team of phlebotomy staff, lab technicians and managers to understand how the service could be changed and share my goals for the project. After process mapping of the delays in discharges around phlebotomy we came up with several changes to implement and trialled them using plan, do, study, act (PDSA) methodology.

Through the changes made to the service I showed increased early discharges in the relevant areas, improving patient flow and freeing up junior doctors to do other tasks in patient care.

Having the time to pursue improvement projects and reflect on myself as a leader has been invaluable to develop the skills needed to succeed as a consultant.



Victoria Stewart

Organisation: Aintree University Hospital

Grade: ST7

Specialty: Acute internal medicine and general internal medicine

Mentor: Dr Tristan Cope

My year as a chief registrar has been the most insightful and challenging year of my training. It has been an excellent opportunity for personal development and it has pushed me beyond my usual comfort zone. The leadership development programme has given me the knowledge and skills to overcome the challenges and adversities I have faced in the role, and it has been excellent preparation for life as a consultant.

Acute medical take list

Aim: To develop and implement an electronic acute medical take list to improve the efficiency and safety of the acute medical take.

The acute medical take is spread over four geographically disparate areas within the trust and with no collective list, managing the take in an efficient and safe manner is challenging. The introduction of a congruent electronic list would overcome these challenges.

Over the last year I have worked with senior leaders and the IT department to develop an electronic list. I have faced some adversities during this project, namely the delayed introduction of an electronic patient record (EPR) system within the trust. I have however persevered and maintained an open dialogue with the IT department and as a result there will be a functional electronic acute medical take list as part of the new EPR system that will meet the needs of the acute medical team and improve patient safety. In the intervening period to implementation of EPR, the IT department will shortly begin work on a temporary electronic acute medical take list which should be completed by September 2019. The completion of this project will be handed over to my chief registrar successor.

I have also had the opportunity to work on many other projects throughout the year. I have introduced a new teaching initiative for trainees and organised a regional consultant job

application study day for senior trainees in the region. I have also been involved with local safety and governance meetings at ward level and helped with the implementation of National Early Warning Score (NEWS) 2 within the trust.

I have also introduced some improvements to the medical handover and developed an electronic doctor handover system for routine weekend jobs for junior doctors. Prior to this electronic system, weekend jobs were handed over from one junior doctor to another on a piece of paper which posed a potential patient safety risk. The new system is safer, accountable and auditable. The feedback from the junior doctors has been positive and it has improved their on-call experience.

The new system is safer, accountable and auditable. The feedback from the junior doctors has been positive and it has improved their on-call experience.



Angus Sutherland

Organisation: Hampshire Hospitals Foundation Trust

Grade: ST6

Specialty: Anaesthetics

Mentor: Dr L Alloway

The chief registrar scheme has empowered me to engage, make change and add value. It has allowed me to reflect on my personal strengths and weaknesses, and presented many challenges and frustrations, giving me a better understanding of what it takes to lead change. It has reinforced the importance of communication. I strongly believe that investing in and engaging with staff and their wellbeing is the key to unravelling the problems facing the NHS, and is vital for improving the quality of healthcare we deliver.

Do we recognise who's sick? Improving communication around deterioration

Aim: To improve multidisciplinary team (MDT) communication when managing deteriorating patients.

National Early Warning Score (NEWS) guidance suggests that all patients with a NEWS score greater than 5 should be seen by a doctor within 30 minutes. With the current pressures of a resource-limited system this is not always achieved. Communication and documentation have a clear impact on the quality of care delivered.

We conducted a baseline retrospective audit looking at 160 sets of notes across all sites of the trust, looking at patients with NEWS2 scores greater than 5 or 3 in one area. It demonstrated that 45% of patients had no documentation of escalation and 60% had no documentation of review of the episode of deterioration. Average time to review was 73 minutes, with a small increase in mortality demonstrated if review was delayed greater than 30 minutes, in patients who were subsequently admitted to the intensive care unit (ICU).

On the back of this we designed a deterioration MDT communication sticker and a deteriorating pro forma for documentation. We involved stakeholders, from all parts of the MDT across both sites, in listening exercises to ensure the

pro formas were targeted to add value. The communication devices have been well received and we're currently undertaking a re-audit of documentation.

The poor quality of our communication around deterioration is likely to reflect how stretched our medical resources currently are. A resource-poor NHS presents us with the opportunity to think creatively around problems. Documentation and communication have a massive impact on the care we deliver and standardising our communication process will hopefully improve the quality of care we deliver to our sickest patients.

A resource-poor NHS presents us with the opportunity to think creatively around problems.



Matthew Szeto

Organisation: Medway NHS Foundation Trust

Grade: ST6

Specialty: Rheumatology and general internal medicine

Mentors: Dr Sandip Banerjee and Dr David Sulch

Being part of the RCP chief registrar network has proved invaluable. This network of motivated individuals facing similar challenges has given me access to resources and ideas that can be adapted as local solutions. Leading change can feel like an isolated journey, so I hugely appreciate the peer support from my fellow chief registrars. From the RCP leadership development training, I obtained further insights into different personalities, which helped me contextualise and navigate some of the more difficult professional relationships I experienced as a clinical leader.

1. Tier 1 doctor workforce strategy
2. Improving continuity of care at weekends
3. Medical registrar rota redesign

Aims:

1. Reduce dependency on locums by providing adequate substantive staffing to medical clinical specialties
2. Improve weekend handover tasks completion rate
3. Improve patient care and medical registrar on-call experience.

1. Tier 1 doctor workforce strategy

- > Re-designed workforce allocation plan and on-call roster based on demand of each clinical area.
- > Created and obtained approval for a business case for 15 additional substantive clinical trust fellows.
- > Projected cost improvement of £500,000 from reduction in locum expenditure.

2. Improving continuity of care at weekends

- > Introduced weekend handover meeting.
- > Reviewed demand of each clinical area and redesigned weekend workforce allocation.
- > Introduced electronic handover platform in partnership with external software developer.
- > Improved weekend task completion rate by 20%.

3. Medical registrar rota redesign

- > Consultation using e-Delphi technique.
- > Matched job allocation to preferences using Assignment Problem Algorithm.
- > Optimised deployment of registrar workforce.
- > Medical registrars reported improvement in patient care and on-call experience.

This network of motivated individuals facing similar challenges has given me access to resources and ideas that can be adapted as local solutions.



Leila Vaziri

Organisation: Oxford University NHS Foundation Trust

Grade: ST5

Specialty: Acute internal medicine and general internal medicine

Mentors: Dr Sudhir Singh, Dr Jordan Bowen and Dr Mridula Rajwani

The chief registrar programme has been an amazing year of challenges which has given me the confidence to promote change when I see an area for improvement in my clinical role. A year of creativity at the same time as being physician in practice. A year of ways to enhance existing leadership and management skills and tailor them with the encountered situations. An excellent year of being part of an invaluable and supportive network in my trust, and through the RCP mentors and other chief registrars, within my deanery and countrywide.

Paramedic direct referrals to senior decision maker: is this the way forward? A pilot project in acute general medicine and ambulatory care at the John Radcliffe Hospital, Oxford

Aim: To decongest the emergency department (ED) by directing an increased number of appropriate paramedic referrals to ambulatory assessment unit (AAU) or the medical admissions unit.

The Oxford University Hospitals AAU was established in 2016 to provide an ambulatory alternative for patients referred to the undifferentiated medical take to meet the increasing demands on acute services. A phone cascade system enabled senior decision-makers to receive all initial calls about medical admissions from referring GPs as well as from paramedics and other healthcare providers. Despite the provision of a direct line to a senior clinician the majority of paramedic conveyances were to the ED. Therefore, a pilot project sought to reduce the number of ambulance conveyances to the ED by removing barriers to paramedics accessing alternative pathways by using existing phone cascade system.

How did we start to create change?

1. A collaborative pilot project was developed by engaging the senior trust leadership, the regional ambulance service and the local clinical commissioning group (CCG).
2. Initial observational data was collected from ED triage.

3. Discussion with the ambulance service leadership to identify barriers to referral.
4. Phone holder availability to referring paramedics increased to 24 hours.
5. Educating phone holders around ambulatory pathways in the region.

In conjunction with an education programme and cross-organisational collaboration the number of discussed patients conveyed to ED by ambulance was reduced by 73%.

Although increasing the availability of senior decision support to non-medical referrers 'upstream' to acute hospital services may reduce ED conveyances further work is necessary to understand the opportunities in terms of cost and economics, as well as professional barriers to widespread adoption.

The number of discussed patients conveyed to ED by ambulance was reduced by 73%.



Shaznin Visanji

Organisation: Barnet Hospital, Royal Free NHS Trust

Grade: ST5

Specialty: Acute medicine

Mentor: Dr Robert Baker

The chief registrar programme has taught me a lot and I would highly recommend it to registrars. It has definitely increased my confidence in speaking to more senior members of staff. My interactions with managers has helped me understand, and given me greater insight into, how the hospital works at different levels. I have truly valued the experience, and it has taught me skills and techniques to become a leader and manager in the future.

'Same-day emergency care' in the new acute medical unit

Aim: To identify and improve any factors in the patient pathway that may prolong a patient's journey from admission to discharge.

Quality improvement projects

A new acute medical unit (AMU) was implemented at Barnet Hospital and consists of ambulatory emergency care (AEC), for those patients 'fit to sit', and ward trolley spaces for those requiring immediate treatment. By working closely with senior managers and directors I was able to make significant improvements.

The twilight registrar was moved into the new AMU. A senior decision-maker at the front door helped standardise the time to initial assessment, investigations and a decision to discharge within 4 hours. A single point of triage ensured all patients were triaged within 30 minutes. A patient pathway was put into place to redirect patients to the unit who accidentally presented to ED. The unit then began accepting patients who have been sent into the ED, by their GP, and have not been formally referred to the nurse navigator or the medical on-call team.

My project has allowed many junior doctors to be involved in quality improvement projects, and consequentially improve their own portfolios, as well as my own, for future job applications.

Reg ready programme

The medical registrar on-call is seen as a particularly challenging role within hospital medicine. Core medical trainees often express concerns about their ability to fulfil this role. I set out to design a structured program, which included lecture-based sessions and the opportunity for hands-on practice with formal feedback.

Rota redesign

I have been involved in the medical senior house officer and registrar rota redesign, to reduce the impact of rota gaps on patient safety as well as improve junior doctor morale.

My project has allowed many junior doctors to be involved in quality improvement projects, and consequentially improve their own portfolios, as well as my own, for future job applications.



Grace Walker

Organisation: Homerton University Hospital NHS Foundation Trust

Grade: ST6

Specialty: Geriatric and general internal medicine

Mentor: Dr Carlo Prina

The chief registrar programme has been an incredible experience, perhaps the most rewarding year of my career to date. It has been hugely beneficial getting insight into how change is implemented at senior levels in hospital. The support of fellow chief registrars has been invaluable, they have inspired me with ideas and encouraged me when things felt tough. My co-chief and I led on a trust-wide programme that resulted in measurable improvements to the care of deteriorating patients.

Homerton deteriorating patient programme

Aim: Improve the care of deteriorating adult inpatients at Homerton Hospital.

Background

We investigated the care of deteriorating inpatients using thematic analysis of unplanned admissions to the intensive treatment unit (ITU), review of escalation and response times and feedback from staff.

Interventions

We formed the Deteriorating Patient Group and implemented:

- > improved handovers; introduction of night handover checklist, improved attendance and integrated nursing presence
- > multi-faceted education programme including *in situ* simulation and National Early Warning Score (NEWS) 2 training
- > escalation and response pathways and critical care referral guidelines
- > night huddles; 1am meeting of hospital at night team to provide support and troubleshoot
- > development of an enhanced hospital at night model with an additional deteriorating patient senior house officer (SHO) grade who supports the ward team responding to unwell medical and surgical inpatients.

Improvements

We demonstrated improvements in our management of deterioration:

- > nursing escalation of patients with NEWS \geq 5 improved from 53% to 80%
- > clinical review in response to NEWS \geq 5 improved from 60% to 78%
- > patients reviewed within an hour increased from 50% to 58%
- > patients reviewed by someone more senior than a foundation year 1 doctor (FY1) increased from 56% to 69%
- > reduction in delays in referral to ITU.

Key achievements and next steps

- > Successful pilot of deteriorating patient night SHO. We have funding agreed to implement a year-long pilot from August 2019.
- > In order to fill the new role we have created acute care clinical fellow jobs that combine clinical work with protected time for personal development in specialties, education and quality improvement.
- > We have secured £10,000 funding from UCLPartners to aid development of a deteriorating patient whiteboard as the next phase of programme.



Rachael Ward

Organisation: Musgrove Park Hospital

Grade: ST5

Specialty: Care of the elderly

Mentor: Mike Walburn

It has been a pleasure to work as the chief registrar and as a RCP representative. It is a pioneering and unique role which has promoted my personal growth, allowed me to enhance and acquire professional skills, and given me the opportunity to gain a unique insight into workings of the organisation from a junior doctor perspective. The current national climate, which strongly promotes a welfare agenda, makes this the perfect time to become a chief registrar. Opportunities to improve staff wellbeing and promote patient safety are endless.

A new era for junior doctors roster management in the medical directorate, Musgrove Park Hospital (MPH) Taunton: Ensuring equity, contractual compliance and proactive safe staffing across all clinical areas.

Aims:

1. Achieve 95% (of 100% standard) of minimum staffing across all medical wards by August 2019.
 2. Ensure in-hours rosters are contractually compliant by April 2019.
 3. Ensure contractual compliance is visible and easily audited.
 4. Agree and implement a standard structure of responsibility for in- and out-of-hours rosters by August 2019.
- > minimum; amber, at minimum; green, above minimum.
 - > The ward staffing levels automatically tally to a central dashboard giving a complete oversight of staffing in the directorate.
 - > Each junior's individual leave, study leave, and rest days automatically tally and go red if they exceed their allowance.
 - > Cross-cover between departments is visually displayed.
 - > Prospective roster building and sharing.

Methods

Quality improvement methodology was used. Survey and semi structured interviews, process maps and audit characterised and quantified the problem.

A rota tool was developed and piloted with the following functionality:

- > Each department's roster is built on a single spreadsheet using a uniform template (customised for each department), visible on the intranet.
- > For each day the number of juniors on the ward automatically tallies to give a visual display of staffing levels: red, below

Early results

Initially the directorate could only prove that 33% of juniors had taken the correct annual leave and that 27% had taken correct rest days. This has improved to 100%. Each department can demonstrate 100% compliance with minimum staffing levels. Survey has shown that 100% of participants think that the system has had a positive impact on patient safety and staff wellbeing, reduced days below minimum staffing and increased confidence filling rota gaps.



Lisa Waters

Organisation: Warrington and Halton Hospital

Grade: ST7

Specialty: Rheumatology and general medicine

Mentor: Dr Alex Crowe

The RCP chief registrar programme has enabled and empowered me to review services, highlight areas for improvement, and influence and implement change in my trust. The chief registrar training days provide a fun, structured approach to quality improvement theories while also challenging individuals to develop their own unique leadership style. I particularly valued the learning action sets which allow for group mentoring in a structured and supportive style. I am confident that the skills, knowledge and experience gained through my chief registrar year will prove vital in my early consultant years.

The art of handover

Aim: Introduction of a safe, multidisciplinary team (MDT)-led, sustainable thrice daily medical handover with educational input.

In one of my chief registrar projects I have led a Care Quality Commission (CQC) 'must do' initiative to improve the safety and effectiveness of the medical handover. Utilising evidence-based recommendations, key stakeholders and feedback we have delivered on the implementation of an MDT-led, structured, sustainable handover process with educational value for trainees.

Key outputs from this project are:

- > medical handover now happens thrice daily in a fit for purpose space with a set structure and is documented
- > there is MDT attendance from medics, human resources, the acute care team and senior management
- > consultant attendance is 100% in the morning handover
- > safety issues raised by on-call doctors are now escalated to the trust safety brief daily via the medical director or acute care nurses
- > intensive treatment unit (ITU) admissions are highlighted to the medical consultant
- > there is opportunity for rota gaps to be highlighted and thus filled

- > there is an MDT-led handover that provides sustainability particularly when trainees rotate
- > team members have been empowered to make further improvements and we are currently working on electronic handover
- > welfare checks happen at handover to ensure team members have had appropriate breaks.

Quality improvement methodology is ongoing to allow for electronic handover of jobs and improved consultant presence in the evening.

Utilising evidence-based recommendations, key stakeholders and feedback we have delivered on the implementation of an MDT-led, structured, sustainable handover process with educational value for trainees.



Gareth Watts

Organisation: Brighton and Sussex University Hospitals NHS Trust

Grade: ST5

Specialty: Acute medicine

This programme has helped me to understand my strengths and weaknesses when it comes to leadership styles. This has been particularly useful when working with people whose leadership styles are different from my own, helping me to find a way forward with my projects. It has also improved my confidence in dealing with management and the executive team, allowing me to be a voice for junior doctors

What is RAMU anyway? Defining and streamlining use of the medical admissions unit

Aim: To review the admission criteria to the rapid access medical unit (RAMU) and reduce the number of RAMU re-attendances by signposting to other outpatient services as appropriate.

The medical admission unit at Princess Royal Hospital did not have a formalised policy regarding the type of referral that would be best managed on the unit. This led to multiple incidences of patients presenting to the ambulatory unit who should be managed more safely in other settings, such as A&E, outpatients or in the community. One-third of presentations to the unit were follow ups. Therefore writing a standard operating procedure (SOP) which included criteria for admission to the unit and for patient follow up to support an early discharge process has allowed for quick identification of patients who are too unwell to be managed on the ambulatory unit, and has given referrers guidelines to help ensure patients are followed up appropriately, either in RAMU, outpatients or by their GP.

Patients requiring semi-elective medical procedures, such as ascitic and pleural drains, were often booked to attend RAMU on days when there were no staff able to perform the procedure. Therefore I created a procedure clinic that these patients can be booked into and is staffed separately from the doctors

managing the medical take. This also provides a valuable training opportunity for the junior doctors.

It is anticipated that we will see a significant reduction in number of inappropriate attendances, allowing the unit to be more efficient in managing patients who have needs the unit can meet.

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The RCP chief registrar scheme 2018/19 yearbook

For further information

Visit: www.rcplondon.ac.uk/projects/rcp-chief-registrar-scheme

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