Beyond The Ward: Reimagining The Outpatient Learning Experien For Internal Medicine Trainees

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NHS Worcestershire Acute Hospitals NHS Trust

Background & Aim

• Outpatient clinics are crucial for core clinical development, helping manage chronic conditions and honing communication skills.

• The IMT curriculum acknowledges the importance of this by stating the expectation of 20 clinic attendances a year alongside 2 yearly assessments in this setting[1]

• Minimum staffing and high workloads frequently were cited at resident doctor forums as barriers to attending within WAHT

• We aimed to improve access to immersive clinic experiences for IMT Stage 1 Resident Doctors by introducing a protected 'Clinic Week' for IMT Year 1 & 2 doctors

Methods

• Created an Standard Operating Procedure (SOP) outlining expectations for resident doctors and volunteer supervising consultants with a timetable of 8 recommended clinics created incorporating already established weekly teaching and dedicated Monday afternoon preparation time.

• Successfully allocated one dedicated clinic week per IMT doctor across the year working with medical staffing to ensure no on call overlap or staffing concerns

• Trainees proactively sourced alternative clinics if scheduled ones were cancelled using the 'Clinic Map' tool already in place

• We distributed comprehensive feedback surveys following the year-long trial to both IMT trainees and consultants

Results

• Survey returns from 9/11 Resident Doctors who completed a clinic week & 5/9 consultants who participated in the trial

• 100% of IMT Resident Doctors agreed the allocated week was useful to their development as a doctor

• Notably increased confidence in communication skills with particular mention to dictating clear, appropriate clinic letters.

• All respondents faced a clinic cancellation but seamlessly found alternatives and felt highly supported by consultants.

• 3 doctors noted the week significantly helped refine their future career aspirations.

• All responding consultants enjoyed the supervision experience and fully intend to participate next year.

100%
Of resident doctors found the week useful to their development

89%
Reported improved communication skills

3/9
Reported they had evaluated or changed career aspirations after the clinic week

'I enjoyed the clinic week and therefore would like to do a specialty that involves clinics in some capacity'

'It made me less afraid of having to run a clinic so I am less likely to be put off of a specialty that has heavy clinic work'

Conclusions

• Providing protected time for doctors to experience a wide range of clinics which they may not be exposed to otherwise has been a positive experience for both resident doctors and consultant colleagues over the course of this year at WAHT

• Looking ahead, we would be keen to expand this scheme further for IMS2 doctors, however this presents challenges with differing clinical commitments in specialist training programmes

• While requiring intensive forward planning with medical staffing to preserve ward safety, this scheme offers a sustainable, replicable approach to improving equitable training access for IMS1 doctors

References: 1. Joint Royal Colleges of Physicians Training Board Curriculum for Internal Medicine Stage 1 Training, available at

Hospital at Night: Reducing Bleep Burden Overnight to Improve Patient Safety and Clinician Wellbeing

Dr Aoife Janmohamed[1,2], Dr Mariyam Izza Shaheed[1], Dr Ceren Kose[1], Dr Francesca Holden[1]

[1]Ashford and St Peter's Hospitals NHS Foundation Trust [2]Associate College Tutor

Ashford and St. Peter's Hospitals NHS Foundation Trust

Background and Aims

- Overnight medical cover (21:00–09:00) is provided by a single resident doctor (SHO) for ~300 beds
- Frequent interruptions can disrupt workflow and increase perceived workload[1,2]
- Baseline SHO survey (n=23) on overnight working:



Aims:

1) Reduce the **mean number of overnight bleeps** to the Night SHO
2) Improve perceived **workload** and **shift manageability** for the Night SHO
3) Support **safer** and more sustainable overnight care provision

Methods

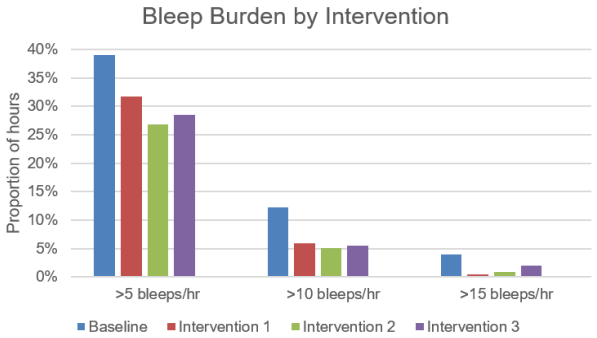
- QIP using PDSA methodology, quantitative bleep-log analysis and qualitative surveys
- Three interventions introduced thus far:

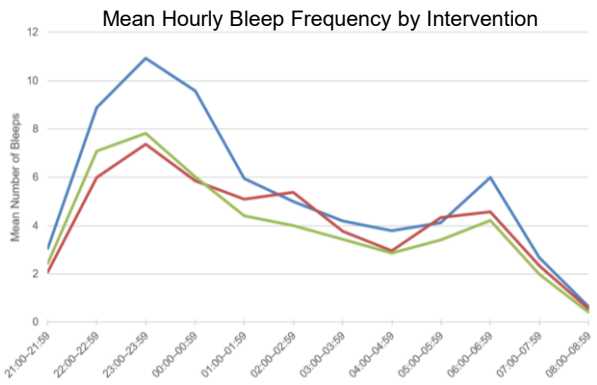
1) Clinical Site Nurse Practitioner (CSNP) triage
2) WiFi phone
3) Increased Twilight staffing

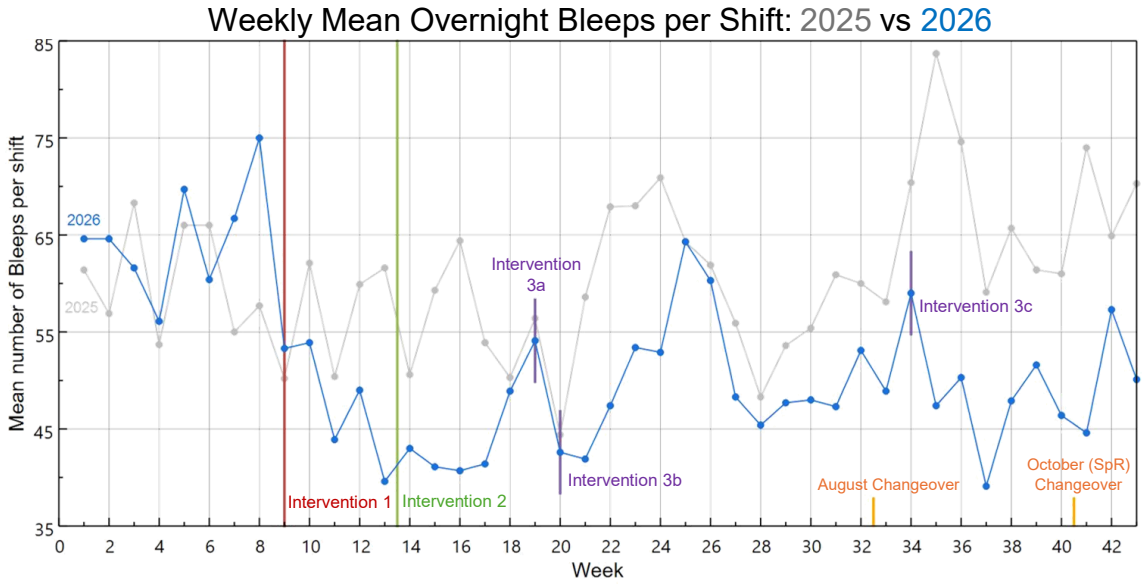
- Primary Outcome: mean bleeps to Night SHO per shift
- Bleep logs from 2025 and 2026 were compared to explore seasonal variation

Results

- Overnight bleeps **decreased by 22.4%** following I1, and **25.8%** after I2. I3 was not statistically significant due to sample size.
- **71.4%** (n=11) reported **improved** perceived **workload and shift manageability** following I1 and I2.







Conclusions

- Implementation of a **CSNP-led H@N triage** was associated with a **reduction in overnight bleeps** (from 64.9 to 50.3 per shift). A further reduction was observed following introduction of a **WiFi phone** (to 48.2).
- No clear reduction in overnight bleeps with increased twilight staffing
- Suggests that a **simple, low-cost** system redesign optimising existing resources may be effective in reducing bleeps
- Further work is still ongoing, focused on **staffing**, auditing bleep **appropriateness** and clinical urgency, ensuring **sustainability** of our interventions with longitudinal monitoring of quantitative and qualitative data, and exploring **alternatives to the bleep** system[3]

References:

1) Weigl M, Müller A, Vincent C, Angerer P, Sevdalis N. The association of workflow interruptions and hospital doctors' workload: a prospective observational study. BMJ Qual Saf. 2012;21(5):399–407. doi:10.1136/bmjqs-2011-000188.
2) Westbrook JI, Raban MZ, Walter SR, Douglas H. Task errors by emergency physicians are associated with interruptions, multitasking, fatigue and working memory capacity: a prospective, direct observation study. BMJ Qual Saf. 2018;27(8):655–663. doi:10.1136/bmjqs-2017-007333.
3) Health and social care secretary bans pagers from the NHS. Available: here [Accessed 25 Sep 2025]

PACES Teaching Programme in a Tertiary Teaching Hospital Trust in the Northeast of England

Dr Christie Mellor, Dr Abbey Smith, Dr Libby Crawford, Dr Richard Buss

Newcastle upon Tyne Hospitals NHS Foundation Trust

Introduction

Prior to August 2025, no formal PACES teaching programme existed within the tertiary hospital trust, despite supporting approximately 50–60 IMT trainees annually, alongside Academic Clinical Fellows (ACFs) and Acute Care Common Stem (ACCS) trainees.

To address this educational gap, a structured PACES teaching programme was established by two Royal College of Physicians Associate College Tutors (ACTs), both of whom had successfully completed the PACES examination.

Aim

The aim was to deliver regular small-group (≤4 trainees) bedside teaching sessions using patients with clinical signs, aligned with the PACES curriculum.

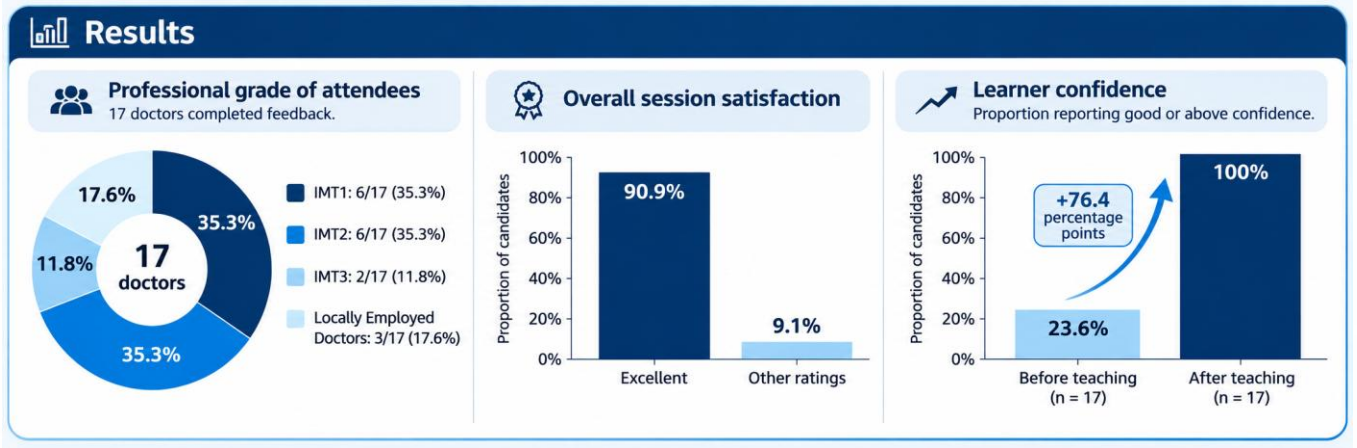
Programme

Between August 2025 and May 2026, 54 sessions were delivered by ACTs, registrars and consultants, with a focus on personalised feedback.

Anonymous quantitative and qualitative feedback was collected after each session using standardised electronic forms.

Results

17 of the attendees completed feedback questionnaires.



Qualitative feedback highlighted personalised feedback, hands-on patient experience, realistic exam-style practice, and high-quality case selection as key strengths.

There was limited critical feedback, with a clear desire for more sessions, and further teaching in neurology and ophthalmology.

Conclusion

The programme demonstrates high educational value, strong learner satisfaction, and clear improvements in trainee confidence, supporting further expansion.

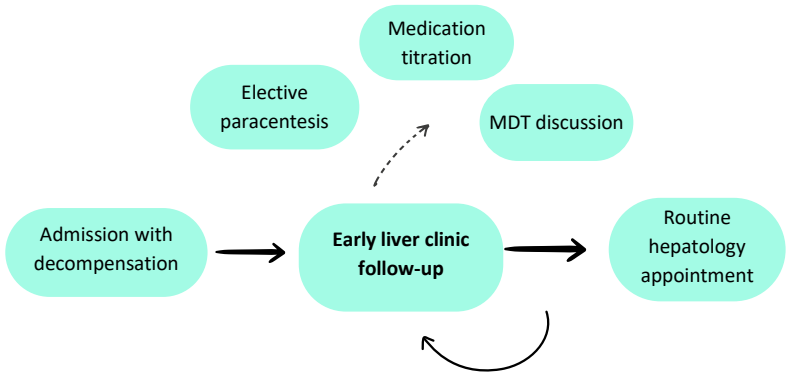
Improving outcomes in decompensated liver disease through early liver specialist nurse follow-up clinic

Daria Krisanova, Torbay Hospital

Torbay and South Devon NHS Foundation Trust

Introduction

- Liver cirrhosis is a major cause of morbidity and mortality in the UK
- In the past 50 years, **mortality** rates from **liver disease** have **quadrupled** in contrast to the fall in the deaths from all major causes [1]
- Standard clinic follow-up after a decompensation event can take months
- **NCEPOD** report recommends "care pathways that include <...> **early clinic follow-up should be established** for patients with decompensated liver cirrhosis" [2]
- Torbay Hospital is one the sites that implemented **a new model of early nurse specialist follow-up clinic**, and its impact has been evaluated in this audit.

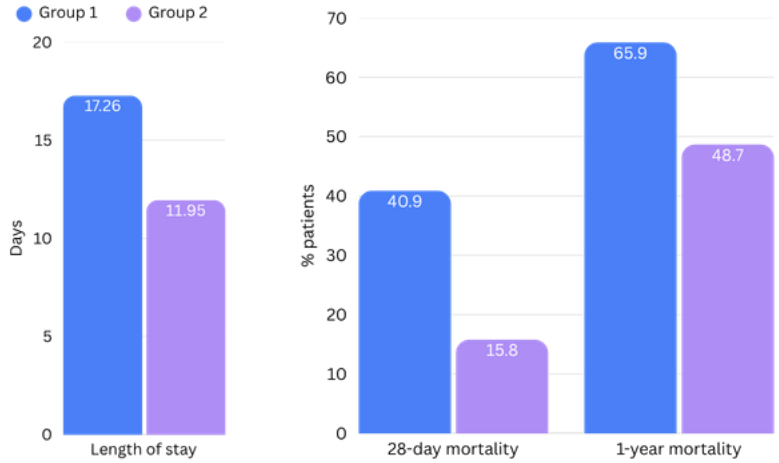


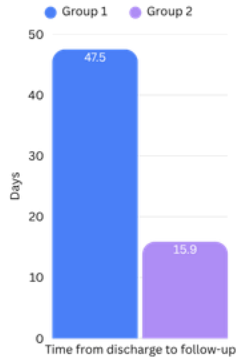
Results

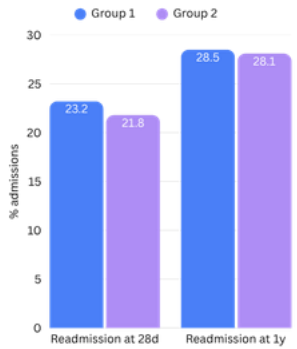
Comparison between two cohorts of patients:

- [Group 1] Mid 2022-mid 2023 (pre-clinic cohort; 56 admissions)
- [Group 2] Jan 2025-Dec 2025 (clinic cohort; 160 admissions)

Included anyone coded as 'Decompensated liver disease' on admission







Discussion

Key findings:

- Average **length of stay** was **reduced by 30.7%** in Group 2
- **Time to follow-up** has **decreased by 66.5%** in Group 2
- Readmission rates remained similar in both groups
- **Reduced mortality** at 28 days and 1 year in Group 2

Limitations:

- Unequal cohort sizes (56 vs 160 admissions).
- Potential under-coding of decompensated liver disease in the earlier cohort.

Summary:

Early liver follow-up clinic cohort was associated with shorter hospital stays, reduced time to follow-up and reduced mortality.

Future:

There is more work to be done to understand the mechanisms driving readmission rates and how to address them, as well as increasing awareness of the service to ensure follow-up is arranged on discharge for appropriate patients.

References

[1] Liver UK. Liver disease in numbers. Available at: https://liveruk.org/about-liver-disease/liver-disease-in-numbers/ (Accessed: 3 November 2026).

[2] National Confidential Enquiry into Patient Outcome and Death (NCEPOD) (2022) Remeasuring the Units: An update on the organisation of alcohol-related liver disease services. London: NCEPOD. Available at: https://www.ncepod.org.uk/pdf/current/Remeasuring%20the%20Units_full%20report.pdf (Accessed: 3 November 2026).

QUALITY IMPROVEMENT • LVAD EDUCATION

A structured LVAD training day improves clinician confidence

Dr Imogen Stokes | Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospitals NHS Trust

AIM

Assess whether a structured LVAD training day improves clinicians' confidence in recognising and managing patients with a left ventricular assist device (LVAD)

METHOD

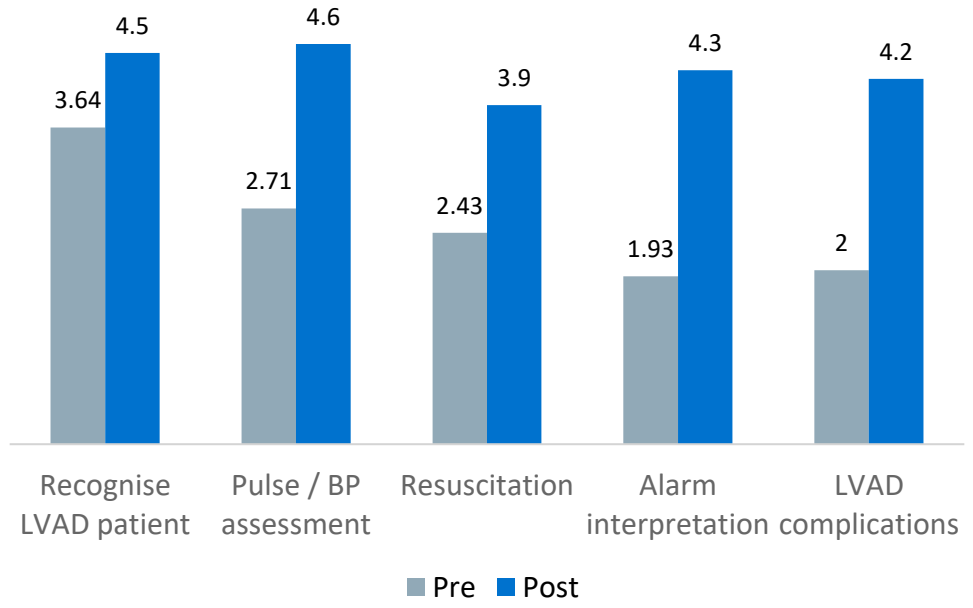
- Pre-course questionnaires n=14
- **Intervention = LVAD training day**
- Post-course n=10
- Assessed using 5-point confidence scale
- Assessed 5 domains related to LVADs

BASELINE COHORT

86% nurses; 14% doctors
43% worked in cardiology
64% reported rare previous LVAD exposure

CHANGE IN MEAN CONFIDENCE

Pre- vs post-training mean score (5-point Likert scale)



Statistically significant improvement in pulse/BP assessment(p=0.0003); resuscitation of LVAD patient (p=0.002); interpreting alarms (p<0.001) and LVAD complications (p<0.001)

STATISTICALLY SIGNIFICANT IMPROVEMENTS

+1.8 Pulse / BP assessment

91.4 Resuscitation of unwell LVAD patients

72.3 Alarm interpretation

72.2 Knowledge of LVAD complications

CONCLUSION

Targeted LVAD education significantly increased confidence, particularly in low-baseline confidence domains. **With statistically significant improvement in 4 out of 5 domains**.

Repeated multidisciplinary training would therefore likely improve confidence in when to escalate concerns regarding LVAD patients and how to manage these patients.

With thanks to Dr Tiffany Kemp, Gary Slater and Guy's & St Thomas' NHS Foundation Trust.

Supported by an educational grant from Abbott Medical UK Ltd. and the Cornish Heart Unit Fund.

RAG-ing the Weekend: Improving Weekend Handover

A two-cycle quality improvement project across St Richard's and Worthing Hospitals

Dr Krishnendu Rajan Nair, Dr Jenanan Mohan, Dr Jashwin Raamasamy Ananth · Supervising consultant: **Dr Bethia Bradley**

RCP CT/ACT National Conference
Liverpool · 13 November 2026

The problem

Resident doctors described weekend ward cover shifts as "overwhelming" with long lists and no way to prioritise. This affected their wellbeing.

206 patients handed over per weekend

Only 12% had a RAG priority (Red, Amber, Green)

1 in 2 asked for a clinical review

Baseline: 1,031 handovers, five weekends, October 2025

Aim

Make weekend handover safer and more efficient by optimising the eAffinity electronic handover form.

Cycle 2 targets: 100% RAG coded · 100% name a grade of doctor · 0% missing clinical information · new virtual review option to ease clinical burden

What we changed

1. **Study the baseline.** Audit of five weekends at both sites, October 2025.
2. **Redesign the form.** Done in collaboration with the IT team. RAG priority, category and grade required all mandatory. "Any doctor" replaced by FY1+, FY2+, Registrar, Consultant. New field: virtual or face-to-face review.
3. **Change practice.** Shared at Local Faculty Group and Grand Rounds. Handovers now agreed with a registrar or consultant; Friday pink sheets record plan, grade and priority.
4. **Re-audit.** Same five-weekend window, October 2026: 818 handovers.

MAIN FINDING

Every weekend handover now says how urgent it is, who should see the patient and whether in person, and nearly half can be done virtually.

0% **"Any doctor" is gone.** It was 62.8% of requests in cycle 1. Now every handover names who should review: FY1+, FY2+, Registrar or Consultant.

NEW **46%** **Virtual or in-person review.** Before the change, explicitly labelled virtual reviews did not exist. Now 379 of 818 handovers are flagged virtual, freeing bedside time for the 439 that need it.

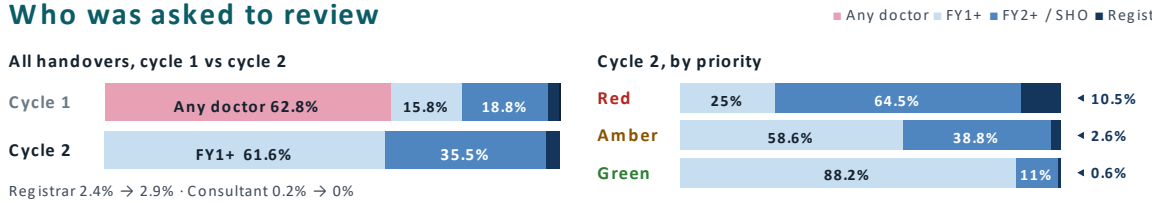
Patients per weekend
206 → **164**
−20.7%, about 43 fewer patients each weekend

Handovers with a RAG priority
12% → **100%**
Target met

Handovers naming a grade of doctor
37% → **100%**
Target met; "Any doctor" was 62.8%

Handovers with no clinical information
11% → **8%**
Target of 0% not yet met

Who was asked to review



What doctors told us

RESIDENT DOCTORS SURVEY

86% said it improved their overall experience (18/21)

86% found it easier to identify urgent jobs with RAG rating (18/21)

81% found arranging reviews easier (17/21)

76% said handover clarity improved (16/21)

> "This made my life so much easier!"

Respondents: n = 21 (F1, F2, IMT and trust grade doctors)

What we learned

- ✓ **Mandatory fields work.** Built into eAffinity, so they do not depend on individuals.
- ✓ **Review type is used sensibly.** Urgent and unwell patients are flagged in person; routine blood checks are flagged virtual.
- ✓ **Senior involvement matters.** Consultants are now more aware of the volume and quality of weekend referrals.
- ⚠ **Complete is not the same as accurate.** Amber is over-used, and the grade requested does not always match urgency.
- ⚠ **"Potential discharge" went unused** (2% → 0%), a missed chance to help weekend flow.

Next cycle

- Teaching on RAG definitions and matching grade to urgency, including Red handovers sent to FY1s
- Push missing clinical information from 8% to 0%
- Audit how virtual and face-to-face reviews are used
- Track sickness absence as a wellbeing measure

Data: eAffinity weekend handovers, five weekends each in October 2025 (n = 1,031) and October 2026 (n = 818), St Richard's and Worthing Hospitals. RAG priority: Red = most clinically unwell, Amber = intermediate, Green = clinically stable.

Medical Induction

Malikah Saba, University Hospital Llandough

Introduction:

Effective induction for doctors is essential to ensure patient safety, maintain clinical standards, and support staff wellbeing and performance. Structured induction programmes familiarise doctors with local policies, clinical systems, governance, escalation pathways, and workplace culture (1). This is especially important in teaching hospitals, where multidisciplinary working and frequent staff rotations are common.

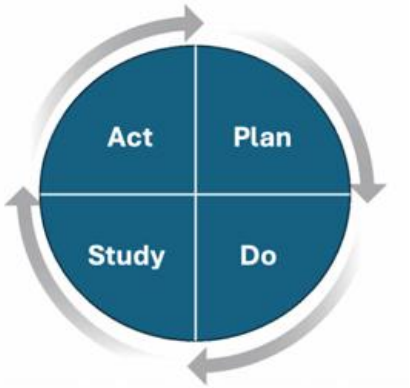
Despite national guidance from NHS England and the General Medical Council, induction quality varies between departments and sites. Inadequate induction may contribute to inefficiency, increased stress, and risks to patient safety, particularly for doctors new to an organisation or transitioning between roles.

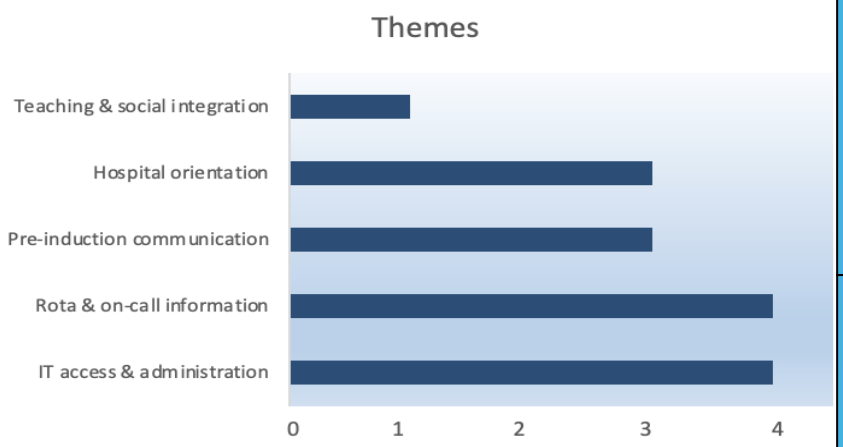
This cyclical audit evaluated doctor induction at University Hospital Llandough, Cardiff, and identified areas for improvement.

Methods:

A retrospective anonymous survey evaluated doctors' experiences of the August induction programme across Cardiff hospitals (n=18). The Microsoft Forms survey was distributed electronically to attendees and cascaded to colleagues to maximise responses across grades and specialties. The survey remained open for two months. Quantitative data were analysed descriptively using Microsoft Excel, while free-text responses underwent thematic review.

Following implementation of the feedback and suggestions provided by attendees, the induction programme was modified and re-evaluated at the subsequent induction held in February (n=9). The same survey instrument was administered to maintain consistency, and responses were analysed using the same quantitative and qualitative methods, allowing comparison between the two cohorts.





Results:

Key concerns included delayed IT access (50% lacked functioning logins on day one), difficulty obtaining ID badges (60%), unclear communication regarding induction timing and location (70%), and delayed or absent induction booklets (50%).

A revised induction programme for February starters introduced pre-distribution of IT logins and induction booklets, QR-code access to local WhatsApp groups, resident doctor representation at induction, and guided hospital tours with support for ID badges.

Discussion:

Targeted improvements based on trainee feedback led to substantial improvements in induction satisfaction and preparedness. Early provision of IT access, induction materials, and local support networks were key drivers of success. Standardised induction processes may enhance both trainee experience and patient safety.

Feedback before QUIP

'I would have liked to be talked through the different clinical apps that are used in the health board and how to request logins (like CAV portal, e advice etc). I did not have access to these for a week which hindered me on the ward. I would have liked a run though of how the on calls work. Including the day returner system, ward round of trolley bay and reviewing anyone overnight in MSDEC.'

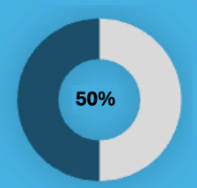
'I was not informed what IT systems I would need or how to sign up to these and was given the wrong information about where to go for ID badges, thankfully I followed other new starters to security and stumbled across an IT drop-in in the library and was able to get things sorted, this would be useful information, including a site map of UHL to include in a trust induction pack to be sent out prior to change over.'

Feedback after QUIP

'Useful to have a summary slide or print out of all the logs in we need to have'

Conclusion:

Following these interventions, satisfaction improved substantially. All respondents reported induction to be appropriate, useful, and easy to navigate, with 100% receiving functioning IT logins and ID badges. Additionally, 100% received induction materials before starting and were familiar with their representative and the local WhatsApp group. Proactive, standardised induction processes can improve the experience of new doctors and support safer clinical practice.



Correct information about induction provided BEFORE QUIP



Correct information about induction provided AFTER QUIP

References:

1. The British Medical Association is the trade union and professional body for doctors in the UK. [Internet]. [cited 2026 Jun 20]. Induction for resident doctors. Available from: https://www.bma.org.uk/advice-and-support/career-progression/training/induction-for-resident-doctors

A LOW-COST, SUSTAINABLE ASCITIC PARACENTESIS SIMULATOR TO IMPROVE PROCEDURAL TRAINING ACCESS, TRAINEE CONFIDENCE, AND PATIENT SAFETY

Authors: Dr Muhammad Waleed Khan, , Leon Hughes, Dr Tehreem Arif Kundi Dr Fawad Muhammad

Background and Gap

Abdominal paracentesis (ascitic tap/drain) is a core medical competency and a common requirement in the management of decompensated liver disease, yet training opportunities can be limited by access to commercial simulation models. We aimed to develop and implement a low-cost, reusable paracentesis simulator to improve trainee access to training and confidence, supporting patient safety.

APPROACH AND DESIGN

A multidisciplinary team (medical education simulation team with senior clinical oversight from the local college tutor and gastroenterology SpR) designed a reusable paracentesis trainer using an unused birthing mannequin as the base. Layered materials were used to replicate abdominal wall "feel": an EVA foam "skin" layer, soft foam to mimic subcutaneous tissue while simulating a peritoneal "give." Ascitic fluid was simulated using a fluid-filled internal bag system made from silicone used to support repeated puncture and reduce leakage. Bowel was represented by differently coloured fluid layers beneath the ascitic compartments, and inferior epigastric vessels were simulated using re-purposed drip tubing filled with red fluid positioned bilaterally relative to the umbilicus within the foam to reinforce safe-site selection. The model was used in facilitated teaching sessions for trainees learning diagnostic and therapeutic paracentesis.

SIMULATOR ARCHITECTURE (CROSS-SECTION)

Base: Repurposed Birthing Mannequin

Layering: EVA & Soft Foam (Mimicking skin and peritoneal give)

Internal: Silicone Bag System
(Self-sealing for repeated punctures)

Safety: Vascular And Bowel Simulation
(Drip tubing (Red dye) for epigastric vessels and green dye for bowels)



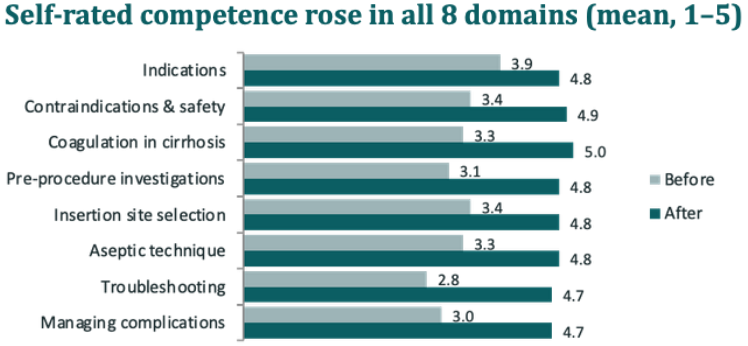


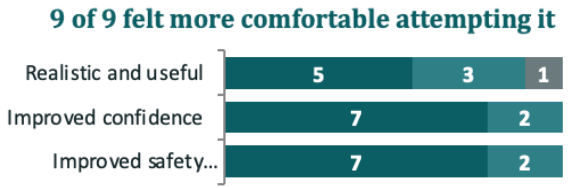


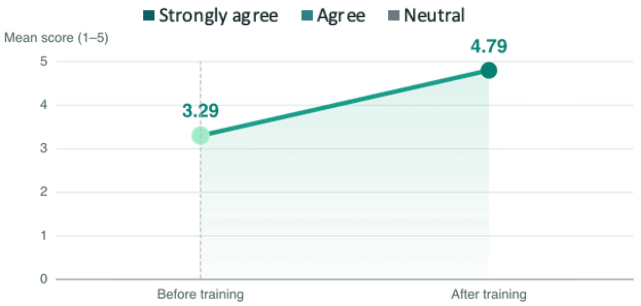
RESULTS & METHODOLOGY

Nine pre-session and nine post-session questionnaires were analysed. Mean self-reported ratings across eight procedural knowledge, confidence and safety domains increased from **3.29/5 to 4.79/5**, representing an absolute increase of **1.50 points.** Improvements were observed across all eight domains, with the largest increase in troubleshooting procedural difficulties **(+1.89 points).**

All nine post-session respondents **(100%)** reported feeling more comfortable attempting paracentesis. All agreed or strongly agreed that the session improved procedural confidence and understanding of procedural safety, while eight of nine **(88.9%)** rated the simulator as realistic and useful.







3.3 → 4.8
Mean rating (out of 5)

CONCLUSIONS, LIMITATIONS, AND NEXT STEPS

Locally built simulators provide a feasible, sustainable alternative to commercial models, directly addressing access barriers.

Integration into formal pathways enhances procedural competence and patient safety in liver disease management.

Limitations: Self-rated, single centre, n = 9, no control group.

Next steps: Observed skills assessment, 3-month retest, real-patient complication audit

DEVELOPING A SUSTAINABLE SIMULATION TEACHING PROGRAMME FOR INTERNAL MEDICINE TRAINEES IN A DISTRICT GENERAL HOSPITAL (DGH)

Dr Phoebe Paley

WHY SIMULATION?

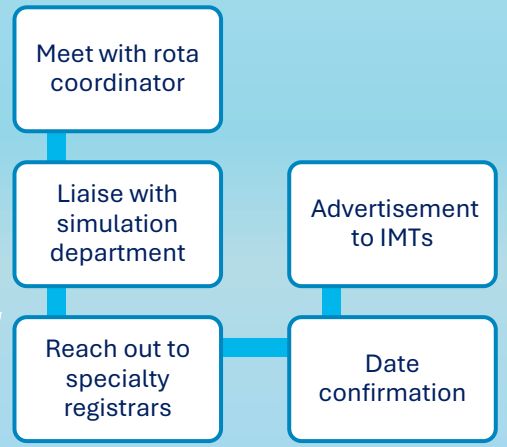
- The Internal Medicine Training (IMT) Stage 1 curriculum states 'scenario-based immersive simulation training should be undertaken… with human factors incorporated'[1].
- A safe environment to develop clinical and non-clinical skills.
- Shown to improve patient outcomes, develop communication skills and teamworking abilities[2].

There was no set simulation teaching programme for IMT doctors at our DGH, with previous years relying on a separate trust for human factors simulation.

AIM

- Establish a sustainable, locally delivered simulation teaching programme, with regular protected teaching time.
- Improve confidence of IMT doctors.
- Offer a safe networking space.

METHOD



RESULTS

- **30 hours** of simulation teaching offered.
- **Protected** time as study leave.
- Facilitators from various specialties including cardiology, elderly care, anaesthetics and intensive care.
- Direct feedback from sessions throughout;
  - **100% strongly agreed** sessions were useful to clinical practice.
  - 90% felt scenarios improved their existing skill set.
  - **Realistic** scenarios for the acute medical take and deteriorating patients.
  - **Supportive** atmosphere.
  - **Knowledgeable** facilitators.



CHALLENGES

- Last minute cancellation from facilitators.
- Occasional poor staffing on wards if study leave submitted late, meaning teaching time not protected.
- Personal preferences on learning with simulation.

CONCLUSION

- Sustainability of such a project requires early planning and close collaboration between departments.
- It is possible to do this as associate college tutor with early organization, flexibility is needed.
- Structured handover required for incoming associate college tutor to continue the programme.

WHERE ARE WE NOW?

- I have completed IMT3 and am no longer at the trust.
- Detailed handover into incoming associate college → three sessions of simulation have already been delivered, with more dates planned in the upcoming year.

REFERENCES
1.https://www.thefederation.uk/sites/default/files/Internal%20Medicine%20stage%201%20curriculum%20FINAL%20111217.pdf
2. https://pmc.ncbi.nlm.nih.gov/articles/PMC11224887/#sec19

NHS
Dorset County Hospital
NHS Foundation Trust

Improving Admission Decisions in Suspected Neutropenic Sepsis

MASCC risk scoring across baseline audit, education and re-audit

Priyanka Balasubramani, Arun Selvaraju and RiazDoha Chowdhury | Basingstoke and North Hampshire Hospital

Low-risk admission rate fell at re-audit

Observed decrease of 3.7 percentage points

53.7%
Baseline (22/41 admitted)

50.0%
Re-audit (8/16 admitted)

What is the MASCC score?

The Multinational Association for Supportive Care in Cancer (MASCC) score estimates complication risk in febrile neutropenia. [1]

Up to 26 points from symptom burden, blood pressure, COPD, cancer and fungal history, hydration, fever onset setting and age.

≥21 Low risk	≤20 High risk

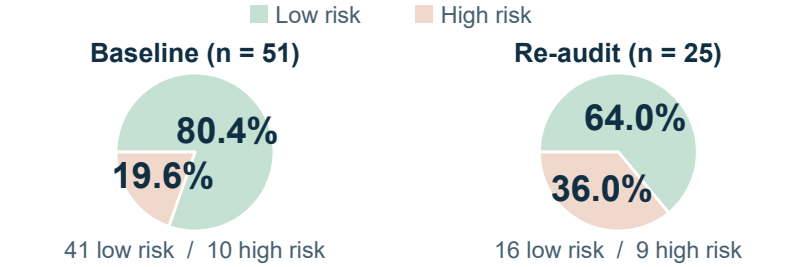
Outpatient care also requires clinical and social assessment and a plan for follow-up. [2]

What we measured

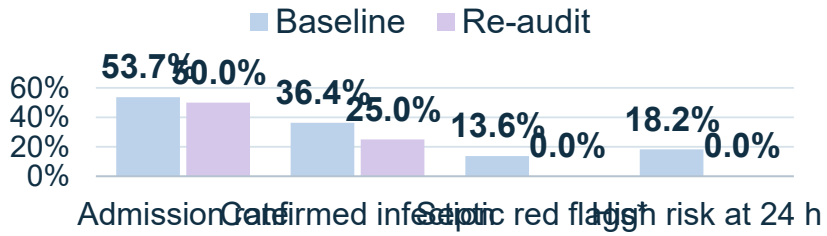
Aim Reduce low-risk admissions and length of stay while monitoring patient safety.

- Retrospective ED and Acute Oncology review, excluding haematological malignancies
- MASCC at presentation and at 24 h if admitted
- Admission, stay, infection and complications

MASCC score at presentation



Outcomes in low-risk patients



Baseline / re-audit n = 41 / 16 for admission, 22 / 8 for other outcomes.
At re-audit, 1/8 had a positive blood culture and 1/8 had a viral infection.

Admission and inpatient outcomes

Measure	Baseline	Re-audit
Admissions, all patients	32/51 (62.7%)	17/25 (68.0%)
Admissions, low risk	22/41 (53.7%)	8/16 (50.0%)
Admissions, high risk	10/10 (100%)	9/9 (100%)
Confirmed infection, high risk	7/10 (70.0%)	2/9 (22.2%)
Septic red flags, high risk*	1/10 (10.0%)	2/9 (22.2%)
Low-risk stay, mean / median (d)	4.0 / 2.5	6.2 / 4.0
High-risk stay, mean / median (d)	8.5 / 5.5	6.1 / 7.0

* Red flags included SBP <90 mmHg or HR >130/min.

After discharge among patients at low risk

At baseline, 1/19 (5.3%) had a confirmed infection. The 2026 QIPAT describes this as a readmission. At re-audit, 1/8 (12.5%) required readmission after a positive blood culture.

Small cohorts and a different risk mix limit interpretation. The follow-up interval after discharge was unspecified.

Change and repeat measurement

01 Baseline audit
Jul–Sep 2023 (51 patients)

→

02 Education
Shared findings at Acute Medical Unit and Oncology Governance meetings

→

03 Re-audit
Oct–Dec 2025 (25 patients)

→

04 Next test (planned)
Add MASCC to the clerking proforma

CONCLUSION | **Low-risk admissions fell at re-audit. Next, test the clerking prompt and track readmissions prospectively.**

[1] Klastersky J et al. J Clin Oncol 18(16), 3038–3051 (2000). [2] NICE CG151. Neutropenic sepsis, recommendations 1.5–1.6.

Development of a Sustainable and Equitable PACES Teaching Model in an Acute NHS Trust

An Educational Quality Improvement Project

R Ullah[1] · A Jones[1] · C McAloon[1] | Worcestershire Acute Hospitals NHS Trust

Worcestershire
ACUTE HOSPITALS NHS TRUST

BACKGROUND & AIM

The MRCP PACES exam is a core curriculum requirement of Internal Medicine training and an important milestone for doctors not enrolled in formal training programmes.

Before August 2025, WAHT lacked structured PACES teaching, creating inconsistent and inequitable opportunities—particularly for non-training doctors.

AIM · BY AUGUST 2026

Establish a sustainable, College Tutors-supported, trainee-led PACES programme that:

- Improves satisfaction, confidence and exam preparedness.
- Provides multi-modal, equitable access for training and non-training doctors.
- Endures through formal SOPs, a PGME intranet repository and College Tutors' long-term oversight.

METHODS · THREE PDSA CYCLES

1 PROGRAMME LAUNCH

Aug 2025 – Jan 2026

Baseline survey · recruitment · revision notes · schedule launch

2 PROMOTION, EQUITY & ACCESS

Feb – Apr 2026

Cross-site delivery · on-demand roster · intranet repository · targeted promotion

3 SUSTAINABILITY & EVALUATION

May – Jul 2026 · in progress

SOP finalisation · post-survey · ACT handover · regional mock circuit

MULTI-MODAL INTERVENTION

- Formal programme SOPs (roles, handover, annual review) · Centralised PGME intranet repository
- Fortnightly Wednesday teaching: consultant masterclasses + bedside teaching · Six-domain PACES assessment tool
- 'Sessions on Demand' with consultants and SpRs · 'Learning for PACES' WhatsApp community + QR sharing · Cross-site delivery

RESULTS

Self-reported resident-doctor ratings of 4–5/5 on a 5-point Likert scale; descriptive analysis only.

SATISFACTION

9% → 90%

Trust PACES teaching

Before 1/11 · After 9/10

CONFIDENCE

10% → 100%

PACES preparation

Before 1/10 · After 10/10

PREPAREDNESS

10 / 10

Rated improvement as 'significant' or 'quite significant'

All post-implementation respondents

LONG-TERM CONTINUATION

10 / 10

Agreed the programme should continue

Unanimous endorsement · 100%

PROCESS At least 7 fortnightly sessions delivered between November 2025 and April 2026; schedule populated through July 2026; successful cross-site delivery at both sites.

LIMITATIONS

- Small samples (baseline n=11; post n=10); descriptive analysis only.
- Self-reported outcomes and retrospective pre/post design are subject to bias; respondents self-selected, with possible non-response bias.

CONCLUSION

STRUCTURALLY EMBEDDED

A centrally hosted, College Tutors-led programme was associated with improved self-reported confidence, satisfaction and preparedness across training and non-training doctors.

EQUITY GAP ADDRESSED

Explicit inclusion of trust-grade and non-training doctors supports resident doctors regardless of training status.

REPRODUCIBLE MODEL

SOP, assessment tool, intranet resources, faculty letter, WhatsApp model and schedule template can be transferred to other DGHs without specialist resource.

SUSTAINABILITY & REPRODUCIBILITY

- Formal SOPs with annual review; centralised intranet repository.
- Structured ACT-to-ACT handover and self-replenishing faculty.
- Recurring fortnightly teaching cadence and reusable resources.
- College Tutors-led, PGME-supported framework designed for replication across acute NHS trusts.

FUTURE DIRECTIONS

- Quarterly five-station PACES mock circuit with regional collaboration.
- Disseminate SOP and intranet template to neighbouring Trusts / West Midlands Deanery.
- Maintain annual SOP review, central repository and structured handover.

CORRESPONDENCE

Dr Rafiq Ullah · IMT Year 3 · Associate College Tutor

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Improving Antibiotic P-Note Documentation Compliance Across 15 Inpatient Wards: A Multi-Cycle PDSA Quality Improvement Initiative

Dr Ranvir Singh Kalra, Associate College Tutor · **Dr Somil Rastogi**, Gastroenterology/GIM ST7 · **Dr Pretin Davda**, College Tutor
University Hospitals Birmingham NHS Foundation Trust

NHS University Hospitals Birmingham NHS Foundation Trust

Background

- Trust policy makes a P note compulsory whenever an antibiotic is prescribed.
- It tells the whole team (doctors, pharmacists, nurses) why the antibiotic was started.
- It supports antimicrobial stewardship: duration, review, and stepping treatment up or down when a new doctor picks up the patient.

Aim

To increase the proportion of antibiotic prescriptions with a completed P note across inpatient wards.

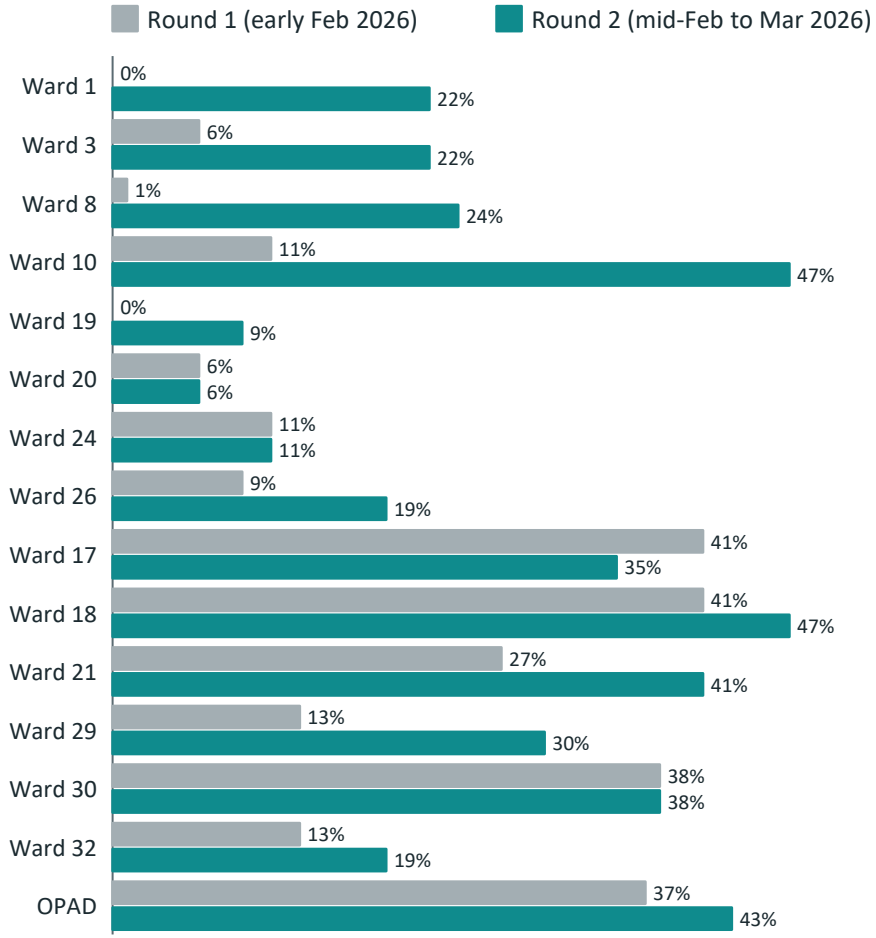
Methods: PDSA cycles

1 **PDSA 1 · July 2025**
Verbal reminders to staff and reminder notes on ward computers. Re-audit 22–23 Jul 2025: no significant improvement.

2 **PDSA 2 · Feb–Mar 2026**
Nominated a lead on each ward and delivered teaching; leads keep on top of P-note completion.

3 **Measure**
Prescriptions on antibiotics and number with a P note, per ward. Round 1: early Feb 2026. Round 2: mid-Feb to mid-Mar 2026.

Results: % of antibiotic prescriptions with a P note



Wards 24 & 26: Wave 1 2–6 Feb, Wave 2 16–20 Feb. Wards 17–32 & OPAD: Week 1 2–6 Feb, Week 2 23–27 Feb. Ward 8 Round 2 collected 9–16 Mar.

Biggest gains

+36
pp · Ward 10
11% → 47%

+23
pp · Ward 8
1% → 24%

+22
pp · Ward 1
0% → 22%

Conclusions

- After ward leads and teaching, compliance rose on 11 of 15 wards.
- Wards 20, 24 and 30 were unchanged; only Ward 17 fell.

Limitations and next cycle

- We measured documentation, not its effect on prescribing quality or C. difficile (CDI) rates.
- PDSA 3: add guideline-appropriate prescribing, IV-to-oral switch and ward CDI rates.

Key message
A named lead on each ward, plus teaching, worked where passive reminders had not.

Establishing a Clinician-Led MRCP PACES Teaching Programme at a District General Hospital: A Quality Improvement Initiative

Dr Ranvir Singh Kalra, IMT, Associate College Tutor · **Dr Saboor Zulfiqar**, IMT · **Dr Shuja Dar**, College Tutor and Supervisor
Birmingham Heartlands Hospital, University Hospitals Birmingham NHS Foundation Trust

NHS University Hospitals Birmingham NHS Foundation Trust

Background

- PACES tests the core clinical skills needed to progress in internal medicine training.
- There was no structured, regular PACES teaching at the trust.
- Trainees reported low confidence in neurology and cardiology stations, reflecting limited exposure and no exam-focused teaching.

SMART aims

- Deliver 3–4 bedside sessions per week within a defined teaching period (Apr–May 2026), ahead of the Jun–Aug 2026 diet.
- Collect pre- and post-session feedback from every session.
- Recruit a faculty across multiple specialties.

Methods

- Needs assessment survey (n=32) to map station-specific weaknesses.
- Faculty recruitment survey across specialties; voluntary teaching rota.
- Afternoon bedside sessions, 4–6 trainees each, mainly IMTs.
- Self-rated confidence before and after each session, plus post-session feedback.

PDSA cycles

Needs assessment
n=32: lack of regular teaching was the main barrier; weakest in neurology and cardiology

PDSA 1 · Pilot
Apr–May 2026: 1–2 bedside sessions a week, feedback after every session

PDSA 2 · Scale-up
4-week survey (n=4): 3 of 4 found mock stations most useful → mock circuit, more sessions, formal faculty rota

Results

36	4–6	75%	32
sessions delivered	trainees per session	feedback response	needs-assessment responses

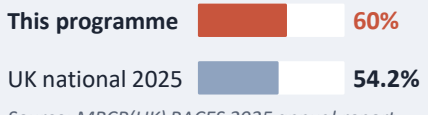
Post-session ratings (n=27): % rating 5/5



Self-rated confidence (mean, /10)



Hard outcome: PACES pass rate



Source: MRCP(UK) PACES 2025 annual report

Measures

Process
2–4 sessions delivered per week; faculty recruited across specialties; teaching Apr–May 2026.

Outcome
Confidence 4/10 → 9/10; 60% pass rate (national 54.2%); 96% rated sessions 5/5 (n=27).

Balancing
Faculty workload kept manageable through a voluntary rota, with CPD teaching certificates as an incentive.

Conclusions and next steps

- Confidence rose from 4/10 to 9/10 and 60% of candidates passed PACES, above the 2025 national rate for UK resident doctors (54.2%).
- Limitations: small cohort, self-rated confidence and no pre-programme local pass rate.
- Next: track pass rates across future diets against non-attendees. Low cost, so other trusts can adopt it.

Project outputs

2	3
leads recognised for organising and leading	postgraduate volunteers recognised for teaching

Certificates of recognition from RCP College Tutors; the project also produced a completed QIP.

A Low-Fidelity, High-Frequency Approach to Simulation for Internal Medical Trainees in a Resource Constrained NHS

Dr Richard Ford & Dr Sabine Bellamy

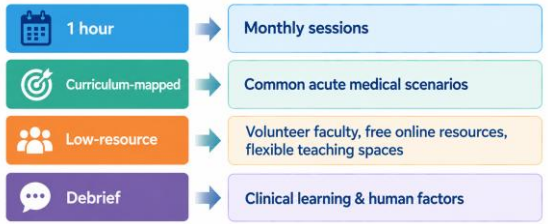
1 The Problem

Simulation is a core component of the IMT curriculum. Locally, exposure was limited to an annual high-fidelity course, while trainees continued to report anxiety around progression to the medical registrar role.

Expanding high-fidelity simulation was not feasible due to limited faculty numbers, lack of simulation space and equipment unavailability.

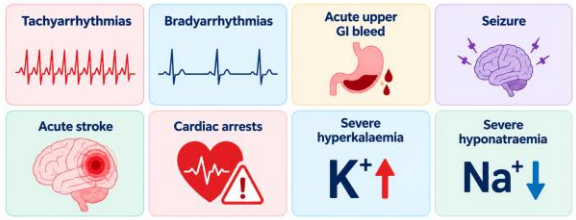
2 What We Did

We developed an adaptable, low-fidelity, high-frequency acute medical simulation programme called 'Crash-Lead-Learn'. These sessions were delivered at the start of scheduled IMT teaching between September 2025 and July 2026.



We designed and delivered scenarios with support from volunteer registrars and consultants, using pre-existing equipment and free resources. Sessions could move rooms at short notice, with fidelity adapted to whatever space and equipment were available, enabling regular simulation without reliance on dedicated facilities or extensive resources.

Simulation Scenarios

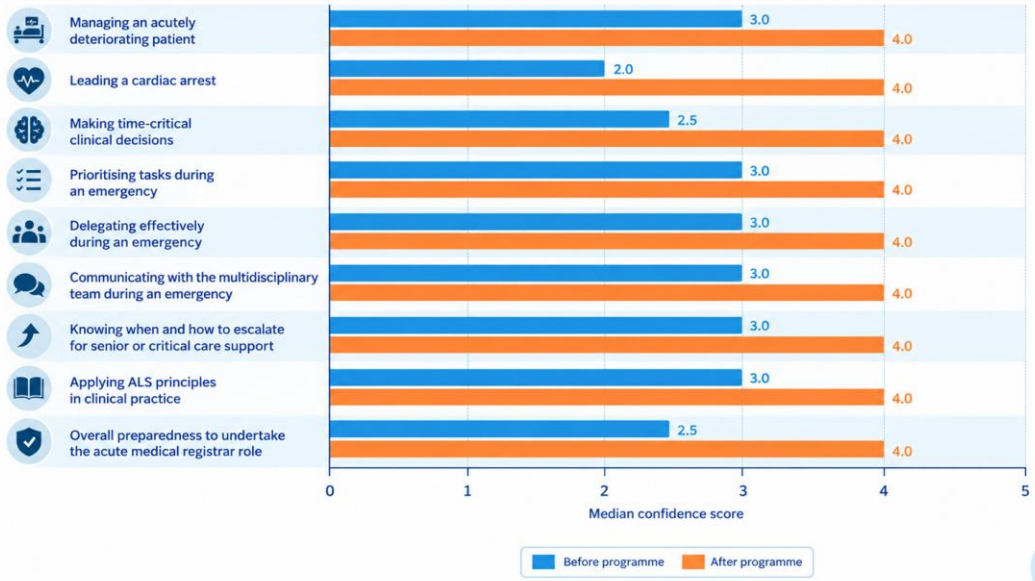


3 What We Found

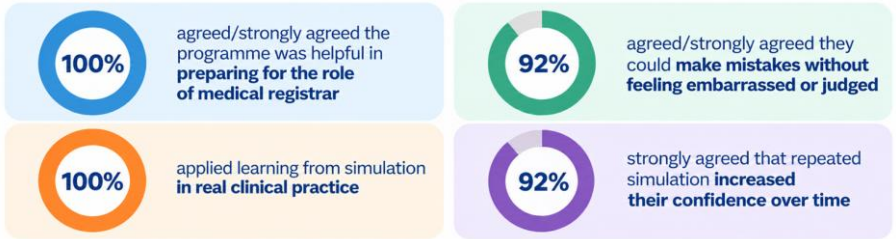
We received feedback from 12 IMTs (5 IMT1 and 7 IMT2).

Self-Reported Confidence Before and After the Simulation Programme

Median confidence scores (1 = not confident at all, 5 = very confident)



Impact of the Programme



4 Why It Matters

Adaptable, low-fidelity simulation provided repeated opportunities to practise leadership and emergency management, helping bridge the gap between clinical knowledge and confidently leading as the medical registrar

Importantly, trainees found the low-fidelity environment psychologically safe - more relaxed, open and comfortable making mistakes as part of learning.

Trainee Voices on the Programme



5 What Next?

Frequent, low-fidelity simulation offers a practical, adaptable and resource-efficient approach to simulation training that can be embedded within routine IMT teaching.

As the programme ran over an academic year, increasing confidence may also reflect trainees' accumulating clinical experience, rather than simulation alone. Therefore, further work should use objective and comparative measures to better isolate the programme's impact, while assessing sustainability and scalability across specialties and other NHS trusts.

A novel education programme for military physician trainees: closing the training gap for a unique group of doctors

Maj Ronan Murphy — **RCP ACT – Army**
Sqn Ldr Luke Swithenbank — RCP ACT – RAF
Surg Lt Cdr David Inglis — RCP ACT – Royal Navy
Surg Cdr David O'Brien — RCP College Tutor – Defence Physicians

Cyber & Specialist Operations Command

1. BACKGROUND WORK → 2. IDENTIFY THE GAP → 3. IDENTIFY SOLUTIONS → 4. CLOSE THE GAP

Introduction

Military consultant physicians are required to be able to deploy **overseas**, where they may encounter **unusual conditions**, with **limited support** and personnel, with limited resources, **without access to UK-standard** treatments, investigations and procedures.

Current NHS internal medicine training[1] does not include these specific skills, and therefore current military physician trainees require additional training to prepare them for CCT.

Specialty-led breakout discussions

Literature review

Qualitative discussion with experienced consultants

Military-Specific Presentations[2]
CBRN
Endemic / tropical infections
Environmental illness (heat / cold)
Envenomation / poisoning
Psychiatric illness

Resource Limitations
No access to endoscopy, PCI, …
Lack of specialty support – including obstetrics, paediatrics, psychiatry

Skills
Thrombolysis
Central access
Ultrasound
Suturing

Specific Roles
Triage / major incidents
Occupational advice
Leadership
Teamworking
Military skills

Challenges

Geography
Funding
Avoid / minimise extending training
Achieve recognition
External assurance



ONLINE 'GRAND ROUNDS'



EDUCATION PORTAL



SKILLS TEACHING



COURSES

Military Unique Module for Physicians (MUMPs)

JRCPTB Joint Royal Colleges of Physicians Training Board — ePortfolios

Discussion: 1. Military physician trainees have unique training needs in addition to JRCPTB curricula
2. A combined methods approach to closing the gap is effective and allows flexibility for busy trainees
3. JRCPTB-endorsed accreditation and ePortfolio inclusion minimises extra training, permits trainee-led development, assures quality and increases sustainability
4. Further work is needed to assess efficacy and refine this model

Acknowledgements and thanks: Col Andrew W
Lucy Lamb, Maj Vishnu Vijayakumar, Surg Cdr Adrian Profitt, RCP GIM SAC

References:
1. Curriculum for Internal Medicine Training. Joint Royal Colleges of Physicians Training Board. 2019 (Stage 1) / 2022 (Stage 2)
2. Cox AT, Lentaigne J, White S et al. A 2-year review of the general internal medicine admissions to the British R3 Hospital in Camp Bastion, Afghanistan. JRArmyMedCorps 2016;162:56-62

From Pilot to Practice: Developing a Sustainable ICU Preparation Programme for Internal Medicine Trainees

Dr Sarah Ahmed, Dr Edward Palmer

Background

Intensive Care Medicine (ICM) is a mandatory component of Internal Medicine Training (IMT), yet trainees at our trust reported a lack of confidence when commencing their Intensive Care Unit (ICU) placements. Feedback highlighted uncertainty around principles of intensive care and organ support.

Aim: To improve IMT trainees' confidence and preparedness for their ICU placements through the development of a structured teaching programme.

Intervention

An IMT trainee-led ICU teaching programme, ***ICU Essentials for IMTs***, was developed in collaboration with ICU faculty. It was delivered within scheduled IMT teaching over three weeks in March 2026.

Informed by trainee feedback and the IMT curriculum, the sessions covered:

- **Core ICU principles**
- **Cardiovascular support**
- **Respiratory support**
- **Renal replacement therapy (RRT)**

The trainee lead identified the educational gap, designed and coordinated the programme, delivered the RRT session, and evaluated feedback.

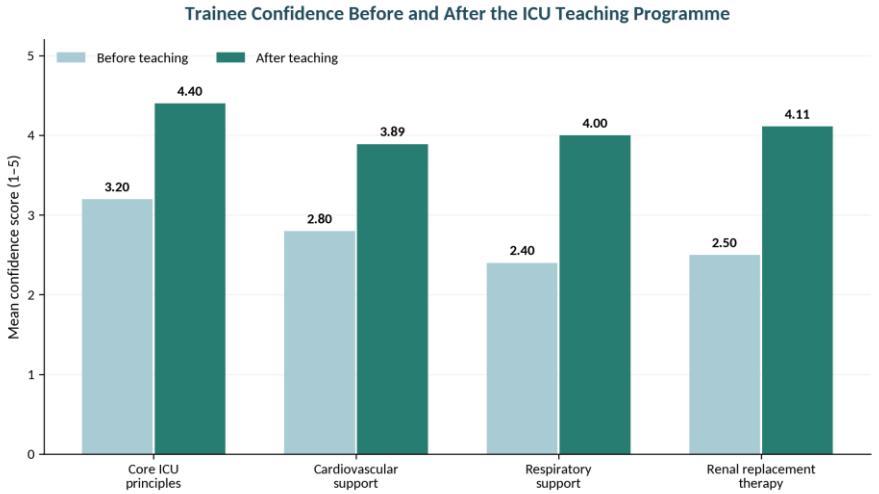
"Definitely would recommend repeating this for every cohort joining ITU"

Results

12 trainees participated, with 10 completing evaluations (83%).

Retrospective pre- and post-course self-reported confidence scores (5-point Likert scale) increased across all four domains. **100%** rated the programme useful or very useful, with **80%** rating it very useful.

Qualitative feedback highlighted its clinical relevance and value in preparing trainees for ICU.



Discussion

The pilot demonstrated improvements in self-reported confidence across all four domains and high trainee satisfaction, supporting the value of structured pre-placement ICU education.

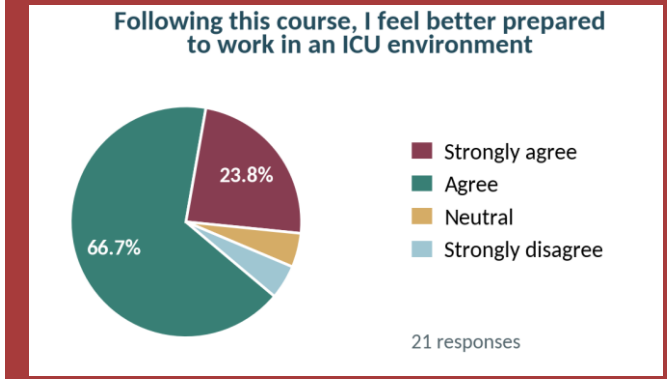
Limitations included the small sample size and reliance on self-reported confidence rather than objective measures of competence.

From Pilot to Practice

Building on the local pilot, a full-day pan-London **ICU Novice Course** was delivered in September 2026, attended by 23 trainees.

The course added practical ventilator and renal filter demonstrations, as well as top tips for ICU.

Of 21 respondents (91% response rate), 81% had not previously undertaken an ICU rotation. All rated the course 4 or 5 out of 5 for usefulness, and 90.5% agreed they felt better prepared for ICU.



Conclusion

This trainee-led initiative successfully expanded from local teaching to a pan-London ICU preparation course, with positive feedback supporting its value.

Delivery is planned three times annually, with feedback-driven improvements aiming to establish sustainable ICU preparation for future trainees.

Whittington Health
NHS Trust

Advancing Simulation-based Training For Internal Medical Trainees Across Wales

S. Davies, S. Abdelgafar, B. Arun.

With thanks to C. Finlow, S. Moore

Background:

Simulation-based training is a well-established educational approach reflected by its mandatory inclusion in the Internal Medicine Training (IMT) curriculum.

Feedback from ACTs across Wales suggested **inconsistencies in access to and delivery** of simulation across Health Boards (HBs).

This has not previously been quantified.

Aim:

Create a Wales-wide data-set characterising IMT simulation experience focusing on **quantity, content** and **value.**

Improve equitable access to high-quality simulation-based training

Method:

We designed a **retrospective cross-sectional survey** sent to all IMT's in Wales exploring simulation provision **between August 2025 and February 2026.**

Results:

- 49 responses across 6 HBx (approx. 25% IMT Cohort in Wales)
- Simulation felt to be 'extremely useful' for training **(4.7/5 average)**

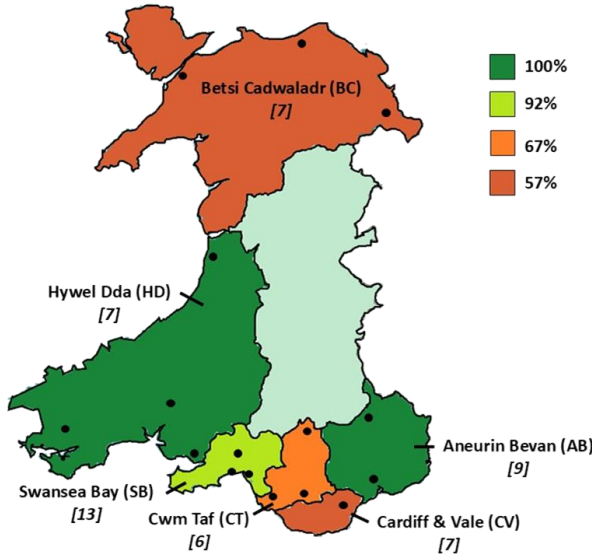


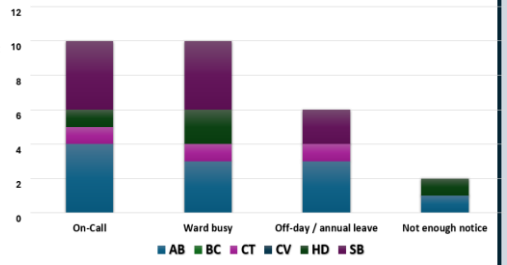
Image1: *Heat Map showing % of respondents in each HB offered simulation. [no. of respondents]*

Quantity:

Simulation was reported to be regular in **HD**, **SB** and **AB** versus 'one-off' in **CV** and **BC**.

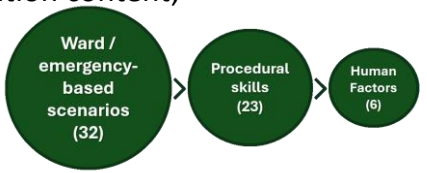
37.5% (15 in 40) of those offered simulation were unable to attend

Graph 1: *Reasons for trainees missing simulation by HB*



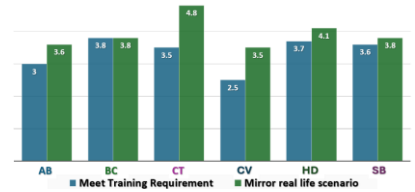
Content:

All HBs offered a combination of simulation content;



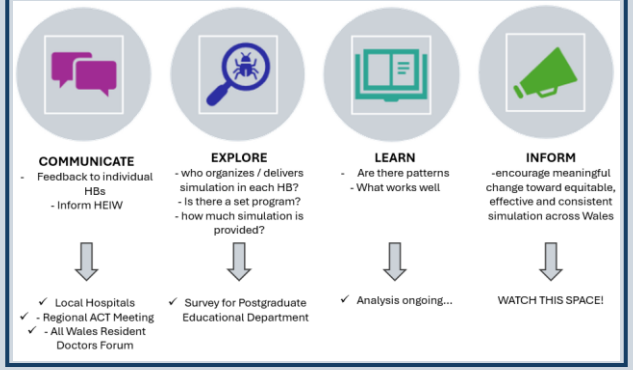
Value:

Graph 2: *Value of simulation across HBs. 1 = 'not at all', 5= 'extremely'*



>50% felt 'Half-day' was the best timing

Next Steps:



Predicting the mistakes before they happen

An AI-assisted simulation programme for IMT doctors

Tarek Al Smadi · Mehar Sethi · University Hospitals Dorset NHS Foundation Trust

1 Why this matters

Simulation debriefs drift toward whichever errors happen to surface. The same high-yield mistakes recurred across cohorts, but were only addressed by chance.

AIM: Can AI predict the errors IMT doctors will make, before they make them?

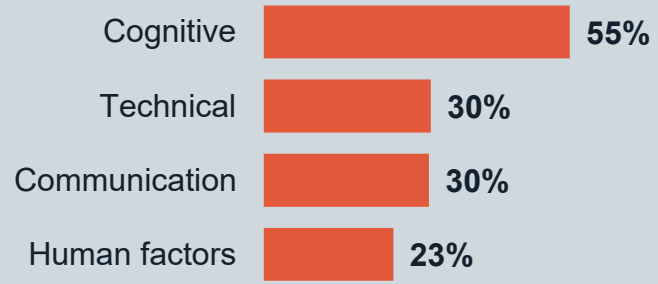
2 How we used AI

1. **We gave it** scenario + objectives + IMT level
2. **AI predicted** likely errors in 4 domains (311)
3. **We observed** which predicted errors happened
4. **We compared** debriefed on the hits

Asthma example: "silent chest missed" ✓ **happened**
"IV magnesium delayed" ✗ **didn't**

3 How often was AI right?

110/311 predictions came true (35%)



4 Programme data

13 sessions

25 scenarios

31 IMT doctors

61 attendances

Oct 2025 – May 2026

5 4 mistakes that kept recurring

19 errors appeared in almost every cohort:

Emergency drug doses
alteplase, magnesium

Waiting for seniors
delaying urgent action

Diagnostic anchoring
e.g. STEMI vs dissection

Procedural hesitation
unfamiliar procedures

6 Impact on trainees

3.05 → 4.47 confidence (n=19)
84% improved, none worse · teaching 4.79/5

WHAT AI ADDED

- **A ready error checklist in minutes**
- **The same debrief, whoever teaches**
- **Revealed the 4 recurring themes**

Supports faculty, doesn't replace them

Peer-Peer and Near-Peer teaching in the IMT programme
Enhancing postgraduate medical education in a DGH

T Stewart, P Chandrasekaran, J Kollathodi, H Onigbanjo, S Jupudi

Portsmouth Hospitals University NHS Trust

Introduction

The IMT programme mandates 50 annual hours of teaching, of which 20 should be recognised for CPD points or organised/ approved by HEE local office/deanery[1].

In this DGH, teaching is overseen by the CTs but organised and delivered by the ACTs.

In the GMC survey the quality of medicine training was self-rated as the lowest across specialties surveyed. NHS pressures and limited consultant availability for teaching were identified as causes[2].

Trainees requested more teaching time as reaching mandatory attendance around rotas was challenging and last minute cancellation for multiple factors by busy senior clinicians was limiting teaching hours provided.

Near peer and peer-peer teaching is well recognised in medical education as being as effective as senior teaching[3,4]. It also helps developed a hidden curriculum fostering confidence in presenting and teaching skills[5]. JRCPTB curriculum guidance states

JRCPTB curriculum for IMT – "Learning with peers - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions[6]."

Method / intervention

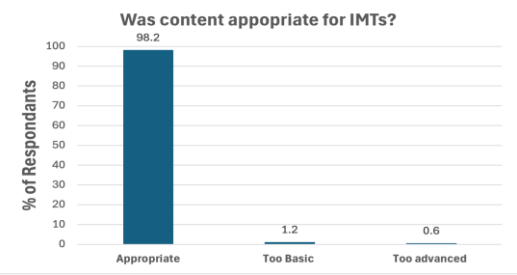
Standard weekly consultant / senior SpR teaching was augmented by an additional peer-peer teaching session.

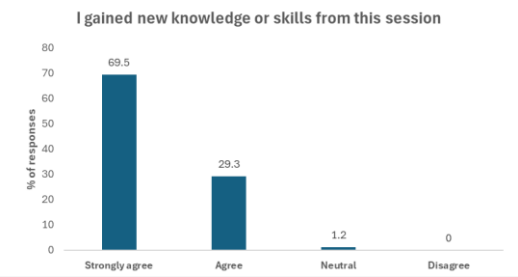
Each IMT was required to deliver a 30 minute session. Free scope was given to pick any topic they felt to be relevant to their IMT peers.

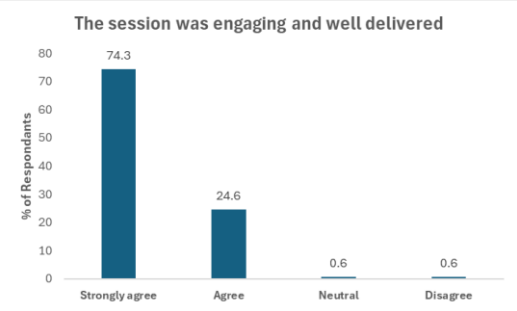
Topics of special interest were encouraged even if not directly aligned to the core curriculum.
52 IMT trainees were given an allocated time to teach.

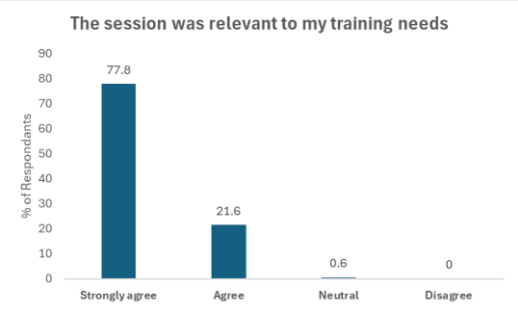
Analysis of the teaching delivered

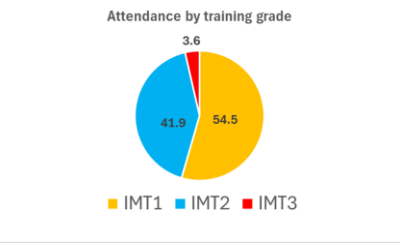
28 sessions of peer teaching were delivered across 9 months. A vast range of topics was covered from common medical problems such as Atrial Fibrillation managed to more specialist area for example (EDAC, Wilson's, small cell lung cancer), special case topics (diving medicine), and more reflective case-based ('Mistakes that made me'). The self-selected topics did not include any repeated subjects. The following graphs show responses to feedback provided at the end of each session.

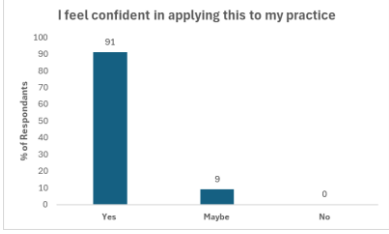












Free text comments were positive of sessions highlighting new guidelines and updates in practice, and those that made sessions engaging through audience participation.

Feedback highlighted a desire for case based teaching and practical guidance and for multimedia teaching methods.

Discussion

Peer and near-peer teaching sessions rated as strongly agree and agree with positive statements about relevance of the content, gaining knowledge, and engaging teaching. This reflects the desire to deliver quality teaching to peers and understanding of the appropriate complexity required at this stage in training.

Case based teaching and use of multimedia delivery was specifically favoured. Developing skills in high quality teaching at the IMT stage will translate to higher quality teaching throughout careers, improving the quality of teaching for future generations.

Self-selected topics were felt to be relevant despite limited guidance to follow the IMT curriculum. A more restrictive list of topics could be provided by this was felt to risk less enthusiastic teaching delivery and risking heavy reliance on guidelines as the basis for teaching rather than experience.

We support the RCP's call for *"clearer national standards, protected educator time in job plans, and investment in core infrastructure.[7]"*
System pressures mean consultant availability for teaching is being reduced and teaching programme organisers struggle to fill teaching programmes. Peer teaching offers an alternative mode to ensure protected teaching is delivered and education opportunities away from the wards are maximised.
Peer-peer and near peer teaching increased overall teaching hours across the IMT cohort.

Key messages on peer and near-peer IMT Teaching

1. Peer-Peer teaching should supplement the consultant led teaching programme to enhance training for IMTs.
2. It provides opportunities to develop special interests and teaching skills.
3. Attendance remains an issue and moving to whole day protected teaching would provide better opportunity to attend teaching to arrange senior supervision of sessions.

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