RCEM QIAT (2021)

Higher Quality Improvement Assessment Tool ST5-6

Part A – For *trainee* to complete

Please use this tool to describe the Quality Improvement activity you have undertaken this year. At ST6 you will be expected to attach a full report of the project you have undertaken for CCT.

-

1 - The project

1.1– Analysis of problem

Please write a description of the problem that you found and why you chose this Quality Improvement Project. Please include your analysis of why it was a problem in your department.

I commenced my ST6 post at the Royal London Hospital (RLH) in August 2021. At the same time, RCEM introduced "Educational Development Time (EDT)" [1]. The default arrangement for trainees at RLH is EDT from 1400 if you are on a day shift. The sheer volume of regular time afforded to me with the sole objective of professional development was striking, and entirely novel. I found the RCEM Training Standards Committee (TSC) EDT recommendations on the RCEM website [1]. In summary:

- 8 hours per week for HSTs; 4 hours per week for CT3/ST3s.
- EDT should be used for curricular activities.
- Strong emphasis that EDT is not limited to non-clinical activities. It should be used for patient facing and non-patient facing activities.
- The time is encouraged to be used for activities outside of the ED where appropriate.
- An evidence log of achievements must be recorded in the e-Portfolio
- Trainees should plan EDT with their Educational Supervisor (ES).

Several weeks into my new job I was struggling to use the time purposefully. The registrar office was full on most afternoons, suggesting several of my colleagues were equally stumped. Most trainees had just rotated to RLH with little idea of how to organise patient facing education outside ED, myself included. And what about the consultant body? I had a corridor conversation with an EM consultant who said many of his colleagues were "not impressed with the EDT situation" as it encouraged trainees to leave the department early.

First, some information gathering was required. I sent out two questionnaires to the registrar and consultant groups.

THE REGISTRAR QUESTIONNAIRE

- 35.7% of registrars were aware of RCEM recommendations for EDT.
- 28.6% of registrars had been using EDT for patient-facing activities.
- 21.4% were logging activity.

Perceived obstacles to using EDT effectively:

- "Having it at the end of a shift, can't join an on-call team at 1400."
- "Not sure who to contact to arrange extra activities."
- "Often have late clinical handovers, which eats into my EDT time." - "I'm tired from my shifts, and feel I have a lack of capacity to organise extra activities."

Suggestions for how EDT could be improved:

- "A prepared list of contacts to organise additional clinical experience."
- "Whole day sessions."
- "Clearer signposting of how to access extra activities."

THE CONSULTANT QUESTIONNAIRE

- 46.7% were aware of RCEM recommendations for EDT.
- 44.4% of ES' were aware of what their trainee was using EDT for.

Perceived obstacles to using EDT effectively:
- "It puts more responsibility on the trainer to parent the trainee. More responsibility requires more time."
- "Culture not established (some trainees think can go home). Links to activities not established yet."
- "It can be easy to become distracted when in a busy shared office within the ED."

Suggestions for how EDT could be improved:
- "A proper way of documentation of EDT so that we know what trainees are doing with their time and not just sitting the office surfing the internet."
- "Have a directory with links to opportunities. Make them as easy as possible to arrange."

It was clear I had unearthed a complex, multifactorial problem.

1.2 – Use of QI methods

Please describe the QI methodology you chose and why, including any analysis or engagement tools you used and how they helped to complete the project.

ISHIKAWA DIAGRAM (appendix 1)
A visual representation of factors contributing to the problem, divided into distinct categories. This helped me strategise the interventions I might employ to achieve change.

DRIVER DIAGRAM (appendix 2)
This illustrated the component parts of the system I am trying to improve. A deeper understanding of the system clarified what elements would be useful to measure and stimulated the change ideas that would ultimately constitute my PDSA cycles.

STAKEHOLDER ANALYSIS (appendix)
After my initial analysis, I made a list of all relevant individuals/groups. I then used a Stakeholder Map which would guide my communication strategy and level of engagement. A description of my stakeholder engagement process can be found in Section 2.2.

MODEL FOR IMPROVEMENT (MFI)
The MFI is a tried-and-tested framework in healthcare and is recommended by NHS Improvement [2]. I felt it was an excellent fit for this project because multiple change ideas of unknown efficacy had been generated by the Driver Diagram. The MFI framework starts by asking three key questions:
1) What are we trying to accomplish?
2) How will we know that a change is an improvement?
3) What changes can we make that will result in an improvement?

Change ideas are then tested on a small scale with a series of iterative Plan-Do-Study-Act (PDSA) cycles, which then informs if an idea should be discarded or implemented and disseminated more widely. For a more detailed description of the MFI applied to this work, see Section 1.5.

RUN CHARTS
Data was collected via a questionnaire sent out on eight separate occasions. Run charts were then used to monitor changes to seven data categories over time. We could then analyse individual changes implemented in each PDSA cycle, and the overall impact of the QIP with respect to our outcome and process measures.

1.3 – What was the aim of the project

Please describe the aim of your project.

The aim of this QIP was to improve trainee compliance with RCEM TSC recommendations.

In view of how recently RCEM rolled out these recommendations, I felt it was unrealistic to aim for 100% compliance.

RLH trainees ranging from CT3/ST3 to ST6 will be 80% compliant with RCEM TSC recommendations for EDT by May 2021.

1.4 – Measurement of outcomes

What measures did you choose and why? What did they show? How did they help to improve the problem?
Please document your progress, any problems and/or unexpected data and include key results eg run charts/SPC (please save in the QI section of your documents on the ePortfolio)

We collected data via questionnaire. It was sent out to all CT3/ST3 and HST trainees on eight occasions. Baseline data was collected on 7th January. Data after five PDSA cycles was collected on 5th May.

OUTCOME MEASURE(S)
I have one outcome measure divided into four component parts: **Compliance with RCEM TSC recommendations for EDT.**

Here are the key figures for each component of RCEM TSC recommendations. Each data point is the calculated average of questionnaire responses.

RCEM TSC recommendation: **All EDT activity should be logged.**
- Baseline: 70%
- Post-PDSAs: 90.6%

RCEM TSC recommendation: **All trainees should be making an EDT PDP with their ES.**
- Baseline: 46.1%
- Post-PDSAs: 81.3%

RCEM TSC recommendation: **All EDT activities should be covering curricular objectives.**
- Baseline: 70.7%
- Post-PDSAs: 85.3%

RCEM TSC recommendation: **50% of EDT activity should be patient-facing.**
- Baseline: 53%
- Post-PDSAs: 58.6%

We were successful in achieving our SMART aim – there was over 80% compliance with RCEM TSC recommendations (all four components) for EDT by May 2022. No shifts, trends or astronomical points were seen in the run chart data.

PROCESS MEASURES

Process measure 1: Trainee awareness of RCEM TSC recommendations
An upward trend (run of 5 data successive data points all going in the same direction) can be seen after PDSA 1. suggesting the EDT Awareness Campaign (PDSA 1) was successful.
Process measure 2: Trainee awareness of how to organise a range of EDT activities
Three values above the median were recorded after PDSA 3, and PDSA 4 was implemented just two weeks later. This suggests those PDSA cycles are likely to have been successful.
Process measure 3: Trainee perception of departmental signposting EDT opportunities
Again, three values above the median were recorded after PDSA 3. The highest came after PDSA 5. Though not a trend, it suggests PDSAs 3, 4 and 5 served their purpose.

NO BALANCING MEASURES
One unintended consequence is the impact of EM trainees being absent from the shop floor during EDT. This could have patient safety implications. The rare and unpredictable nature of these situations make data collection a challenge, and so this balancing measure wasn't used.

COMMENTARY
Some tentative conclusions have been described above as there appears to be signalling in the data. However, they must be interpreted with caution in view of the small number of data points.

Early February was the doctor change-over period, which clearly influenced the data. There was an immediate drop-off in logging EDT, planning EDT with ES, awareness of how to arrange EDT activities, and perception of departmental proactivity. This was despite me delivering a 15-minute presentation on EDT at the new doctors' Induction.

1.5 – Evaluation of change

What changes did you decide to make during the project and how did you implement them. Describe your PDSA cycles. Please evaluate the changes, including analysis of data and what was learnt. (For projects that are incomplete at ST5, please describe your planned changes).

PDSA CYCLE 1 - EDT AWARENESS CAMPAIGN
Plan and Do
EDT is an entirely new concept to trainees and supervisors alike. Therefore, a logical first step was an EDT Awareness Campaign. This PDSA cycle was a combination of multiple small interventions, and consisted of the following:
- An email to the registrars explaining how to book EDT on HealthRota: 14th January.
- 2nd February: Induction Day for registrars. I delivered a 15-minute presentation which included a description of EDT, the RCEM recommendations, and the QIP.
- 3rd February: 14 posters hung in the registrar office and consultant offices (appendix 4). The poster includes a QR code which takes the user directly to RCEM recommendations.

Study and Act
The team felt that process measure 1 - "trainee awareness of RCEM TSC recommendations" was a reasonable marker for the campaign. We made considerable gains (70.7% vs 91.6%).

87.2% of EDT was initially planned with trainees' ES after PDSA cycle 1. However, this measure dropped off thereafter which is difficult to explain. New starters, with less exposure to the campaign, are likely to be a factor, but one would hope their ES' would safeguard against this to a degree. There is the possibility that ES group were less engaged by the campaign.

PDSA CYCLE 2 – INTRODUCTION OF RLH EDT LOGBOOK
Plan and Do
If RCEM are requesting that all EDT activity is logged and uploaded to the e-Portfolio, there should be a standardised logbook. The projected benefits of the EDT logbook were:
- Encouragement logging activity
- Encouragement of more patient-facing activity
- Encouragement of more curricular activity

The logbook was emailed to all registrars on 22nd February.

Study and Act
Our data demonstrated that 90.6% of EDT activity was logged by the end of the QIP. Interestingly, there was a fall from 81.8% to 71.4% in the first data collection post PDSA 2. This is highly likely to be a result of new starters in early February. Compliance increased in the data collections that followed.

PDSA CYCLE 3 – EDUCATIONAL PARTNERSHIPS WITH ANAESTHETICS AND TRAUMA ANAESTHETIC GROUP (TAG)

Plan and Do

I knew that anaesthetics would be a popular EDT activity. HSTs with a PHEM or ICM interest require currency with critical care and airway skills, and COVID 19 training recovery plans were a priority for two of our ST3s who were redeployed to ITU during their anaesthetics rotations.

The key to success in this intervention would be careful stakeholder engagement. I detail this in Section 2.2. Once verbal agreements had been reached with anaesthetics and the TAG, I followed up meetings with summary emails. Next, I organised an anaesthetics and TAG "rota" for EM trainees on Google Sheets. I then emailed the registrars which included logins for the anaesthetic rota system, instructions for the day, and expectations of professional conduct.

Study and Act

There was clear signalling in the data that this intervention considerably improved trainee perception of departmental proactivity (48.5% vs 86.6%) and trainee knowledge of how to organise EDT (45.7% vs 80%). Furthermore, we found highest values for logging EDT activity after this intervention (95%). This suggests that well-defined educational partnerships with specialties increases the likelihood that trainees will log their EDT, which may reflect a broader engagement with the EDT process.

PDSA CYCLE 4 – RLH EDT DIRECTORY

Plan and Do

This intervention required the most time and energy from the team. We planned to create a comprehensive Directory of EDT opportunities, with descriptions, key contact details and joining instructions. This was a huge undertaking, and I am grateful to my team for their hard work and engagement skills in acquiring these opportunities. The Directory was emailed to registrars as a word document containing multiple hyperlinks on 15th April.

Alongside anaesthetics and TAG, opportunities now exist with clear EDT protocols for: Community emergency medicine, Critical care, Radiology, Point-of-care ultrasound, Trauma surgery, Neurosurgery, Trauma geriatrics, Fracture clinic, REBOA training, Police Trauma Support Team, Maxillo-facial surgery, Obstetrics and gynaecology, Emergency Nurse Practitioners, Paediatrics, Shifts with EM clinical educator (for workplace-based assessments), Research activities, Faculty Development

Study and Act

Our data did not immediately reflect the impact we were anticipating. There was an initial fall in the process measure we felt would improve - perception of departmental proactivity (86% vs 82.1%).

Additionally, a component of the outcome measure - percentage of patient-facing activity – also fell unexpectedly (55% vs 50%), though this was not concerning as 50% is acceptable. These findings are most likely due to natural variation. However, the lack of a demonstrable improvement might be explained by the EDT Directory being emailed out as a word document as opposed to existing on the intranet/hub.

PDSA CYCLE 5 – ALL EDT RESOURCES ON THE "HOW2"

Plan and Do

Multiple resource documents now existed for EM trainees:

- The original RCEM TSC Recommendations document
- EDT Poster (with QR code linked to the above)
- RLH EDT Logbook
- RLH EDT Directory

The team felt that this information needed to be available in one folder on the Bart's Health "HOW2" – part of the Trust intranet. This would improve access and broaden the reach of the project. All resources went live on the HOW2 on May 4th, and this was flagged in an email to the entire department.

Study and Act

Following this intervention, we recorded the highest values of the project for the following measures:

- Percentage of patient facing activity (58.6%)

- Trainee knowledge of how to organise a range of EDT activities (95.3%)
- Trainee perception of departmental proactivity in signposting EDT opportunities (94%)

SUSTAINABILITY
Four EDT Showcase sessions will be held during teaching in July. This will be an opportunity for trainees to share their EDT experiences – the successes and failures – and offer opinion on how to improve the process. I met with Dr. AW on 22nd April to discuss the idea of an EDT Consultant Lead.

Proposed EDT Lead responsibilities:
- Overseeing EDT for the trainee group. ES' monitor individual trainees, but the EDT lead will police the broader group where appropriate.
- Maintenance of departmental awareness of RCEM TSC recommendations.
- Maintenance/development of EDT directory
- Advocating for trainees if they are not getting the time they are entitled to.

On 4th May Dr. AW confirmed this role would be implemented.

2 - Working with others

2.1– Team working

Please describe your team. How did you choose them? How did the team work together? How did you encourage others contributions? How did you manage any conflict? Consider how team behaviour science might apply to your team.

This was a sizeable project. I needed a team around me to deliver results. My role was to lead the team. I designed project strategy (SMART aim, measures, PDSAs), delegated roles to my appointed team members, collected and analysed the data, and completed the write-up.

My first appointment was Dr. TP (EM consultant). As rota lead, he had good knowledge of EDT, as he needed to build a rota around it from August 2021. He was well positioned to be educating the trainee and consultant groups during the awareness campaign as a relatively recently qualified consultant. Tom was the team member I worked with most closely and consulted with on a weekly basis regarding QI methodology and strategy. We also designed the information-gathering questionnaire tool together.

Dr. MM is a paediatric ST3 and current RLH Education Fellow. We worked together at another Trust on a successful educational project. I was keen to have her involved because she is a highly organised, driven, goal-oriented person who consistently delivers. She has considerable experience with data collection, so I delegated the task of designing the data collection tool to her. She also built the paediatric component of the EDT Directory.

Dr. AWe is an EM consultant and RLH Trauma Director. She declared her interest in the project after the initial survey. She explained to me in a chance corridor meeting that she had wanted to design a Directory for trauma services at RLH for some time. She used her influence within the trauma service at RLH to acquire multiple interesting and diverse trauma-related options for the EDT Directory.

Dr. DF is an EM ST6 with recent experience of leading a QIP. He and I worked together organising a regional teaching day at RLH this year. He demonstrated excellent communication and engagement skills when organising the event, and so I invited him to join my QIP team to work on the EDT Directory.

My team remained motivated throughout because I believe I was clearly communicated the purpose of our work, and the specifics of what I needed from them.

I did not bring the team together at any point. Each member joined the process at different moments, and they all had specific roles. With the project was underway I saw no benefit in arranging meetings. On reflection that was a failure of leadership on my part. Had a meeting been arranged, team members may have been more motivated with a sense of a shared purpose (see Section 3.1 for more on this).

The only conflicts I encountered with members of my team were the team members' competing workloads. This was especially the case for consultants Dr. TP and Dr. AW. I managed this by being patient with email / text responses. There was rarely a need to push for an immediate response and so I felt their ongoing engagement with the project would endure if I was calm and non-confrontational.

2.2 – Stakeholder engagement

Please describe your stakeholders. How did you prioritise them? How did they affect the changes in the project? How did you manage any conflict or problems?

EDT is not an easy "sell" to the uninformed. Taking clinicians out of a busy ED has potential patient safety implications, because it increases service pressures on nursing and medical ED staff. ED performance might suffer, as does the pressure on hospital bedspace. Therefore, "capturing hearts and minds" by effective stakeholder engagement was crucial, not only for this QIP, but to the future of EDT at RLH.

Please refer to the stakeholder map in Appendix 4.

"WORK WITH"
The was the group I needed to communicate with most rigorously. I was in regular email contact with "ED-based" members of that category throughout the project. I held multiple face-to-face meetings with the Dr. AWo and EM College Tutor Dr. MM, to keep them informed of progress. Wherever appropriate, I would update fellow trainees and EM consultants informally. I found this straightforward – the majority had "bought-in" to varying degrees early in the process.

The initial questionnaire revealed some negative attitudes towards EDT from EM consultants, and so I was anticipating a degree of reticence from that group. I was pleasantly surprised by how receptive and engaged almost all of them were. It is likely my relative familiarity with these individuals personally was a reasonable influencer here. However, I think the crucial ingredient was bringing Dr. TP into my team who, as mentioned, had an excellent grasp of EDT and passionately advocated for the QIP.

Consultant educators from neighbouring specialties also fell into this group. Their engagement was critical for building educational partnerships which would open up opportunities for EM trainees –they are highly influential, but less interested/invested. I found them less likely to respond to emails, and there were some last-minute meeting cancellations.

A particularly important element was engagement with anaesthetics. After a long email exchange, I managed to secure a meeting with Dr.SL, the anaesthetics College Tutor. The meeting was also attended by Dr. MM which increased my credibility. My goal in this meeting was to arrange a regular reserved "slot" for an EM trainee in theatres. Dr SL was initially reluctant as there had been issues in the past with the professional conduct of EM trainees. By demonstrating an understanding of her reluctance, and clearly explaining the respect with which EM trainees would treat an opportunity to spend time in theatres, I was able to negotiate a weekly shift for EM trainees, formally included in the anaesthetic rota.

Equally careful stakeholder engagement was required with the TAG lead Dr.DN. As in the meeting with Dr SL, he was initially reticent. Using the "WIIFM (what's in it for me?)" approach [4], I explained how EDT represented a golden opportunity for collaboration and shared learning. An arrangement would establish a closer relationship between two leading branches of the trauma care MDT, with the potential for fostering joint QI and research initiatives. A few weeks later, Dr. DN emailed me a comprehensive TAG rota specifically for EM trainees, where 2-3 slots per month were protected for us.

A final engagement challenge in the "Work with" group was the radiology department. Dr. SC, consultant radiologist, was initially unresponsive to emails. I had a chance meeting with her at a trauma radiology teaching session and used the opportunity to describe EDT. She was keen to contribute, but unsure how Radiology could support EM trainees. I explained the place of point-of-care ultrasound in our curriculum, and how familiarity with cross-sectional imaging is increasingly important for emergency physicians - particularly those in tertiary centres who may need to look at external referrals. It required further dialogue, plus prompting from the Trauma Director, and eventually Dr. SC produced a comprehensive menu of daily radiology EDT opportunities, all of which entirely appropriate for EM curriculum coverage.

"INFORM"
The stakeholders in this category were interested, but less influential on the process. This required a less intensive communication strategy. Our approach with this group was mostly email contact with pertinent updates. The ED rota co-ordinator was a recipient of all email correspondence regarding how to book EDT on HealthRota. Nursing staff, ENPs and ACPs were emailed with the EDT Directory and later informed of the presence of EDT resources on the HOW2 in case they had an appetite for engaging with some of the learning opportunities.

Some external EM consultants were made aware of the project by members of the project team. Dr. NJ (EM consultant, NUH) contacted me with a view to rolling out the EDT logbook to her department. I decided to keep her informed in the same way I was with RLH EM consultants, in case other developments might prove useful for her. This was a vote of confidence that the work was potentially worthy of being rolled out Trust-wide.

I included patients in this group as they will always be an interested party when a project ultimately has the potential to increase the quality of care they receive. However, the decision was taken not to inform them as they were not directly affected.

"SATISFY"
On reflection, I see this group of stakeholders as a missed opportunity. HEE and the RCEM TSC are highly likely to have been interested - EDT will have impacted the majority of EDs across the UK after all. I failed to engage with either institution. I was unsure of how to frame my approach to them and the specifics of what I needed help with. Perhaps I am also guilty of not “thinking big” enough.

Both organisations are likely to have had insight into the process of embedding a new educational process into hospital culture. The RCEM TSC may have offered us an even deeper understanding of how EDT could shape the future of EM training, which in turn would assist our “capturing hearts and minds” campaign.

"MONITOR"
This was the low interest/low influence group. My communication strategy here was to respond to requests, but not to actively engage. ED SHOs often use the registrar office for administrative work, and so are likely to have seen the numerous EDT information posters on the walls. This resulted in one of them emailing me directly to ask for a copy of the EDT logbook.

I included the Kaizen e-Portfolio platform in this group. I felt they might be interested in the EDT logbook intervention. It could easily be embedded into the Kaizen record for trainees across the country to use. I felt it was important to conclude the project, with evidence of completed logbooks by trainees’ at their ARCPs, prior to engaging this stakeholder. This will be handed over to the future EDT Lead.

2.3 – Patient and carer involvement (if possible)

Please describe how this project has improved the quality of care for patients or carers. How did you engage and/or involve the patient/carer voice in the change?

My belief is this project will have improved the quality of patient care. However, as with any educational innovation, that is difficult to prove.

It will do so in two distinct ways:
- By introducing a better “educational infrastructure” for EM trainees – this will help to build higher quality EM consultants of the future.
- By fostering new educational partnerships between specialities – this will build better multidisciplinary teams, stimulate joint training and project work.

3 – Reflection on leadership and learning

3.1– Self awareness

Personal qualities -
"What is it about you that enabled this project to improve patient care, or why did you struggle?"

Please reflect on your own personal qualities and how these affected the project. Self-awareness, values and beliefs; Your personality and how this might drive your behaviour; Seeking feedback; Your strength and weaknesses; Working under pressure; Managing conflict; Your well-being.

This project has been objectively successful. It has undoubtedly been a team effort, though I do think some of my personal attributes are significant contributing factors. I am an extrovert. One of the reasons I love my chosen specialty is that I am happiest when around other people, talking and listening. By nature I am enthusiastic and positive, and I like to think others enjoy working with me for those reasons. I am a skilled storyteller – I can spark the interest of an audience, make them clearly understand why something is worth being passionate about, and motivate them into action if required. When considering the Diffusion of Innovation Model, I believe I am capable of persuading Late Majority or Laggards [4].

My capacity to "think big" has also been a useful trait. I saw the transformational potential that EDT has for EM and beyond, which consistently motivated me. It also helped me secure an ambitious arrangement to ensure sustainability. Having said that, I failed to "think big" enough when it came to engaging some prominent stakeholders - HEE, RCEM and Kaizen.

I believe my extroversion and ambitious nature are qualities that served me perfectly for this project, which at its core, was about relationship-building. I was able to clearly convey my vision for EDT at RLH, and why it I believe it has the potential to benefit all members of the acute care MDT. I felt like I was "on a mission", and that mindset inspired me to do some work I'm truly proud of. The stakeholder engagement process, especially with regards to building the EDT Directory, was a true highlight of my training.

I have been asking myself regularly "what type of leader am I?" during my HST, and particularly this year at RLH. I have learned that I feel comfortable as a collaborative leader. I like to ask for other's opinion and to involve my team where possible. I believe it enhances decision-making and, if managed correctly, does not diminish a leader's authority. I collaborated regularly with one member of my team in particular – Dr. TP. I learnt a great deal from his approach to QI methodology and his logical, pragmatic thinking.

My weaknesses include time-management and scheduling. Unfortunately, these surfaced occasionally during the project. My biggest error was failing to organise a team meeting to share my vision, motivate, and establish common goals – a missed opportunity.

Another of my reflections is, with a better grounding in QI methodology from the outset, I may have collected more data from multiple sources (e.g. the ES' as well as the trainees) to paint a more detailed picture. It might be argued that I rushed to start the project out of an eagerness to proceed, though in my defence I had an ARCP deadline. Ultimately, I am unsure if my interventions would have been any different – I believe they are all well planned, well executed, and sustainable. However, perhaps some more robust data to give additional strength to the arguments I am making about EDT would be helpful.

3.2 – Learning

Longitudinal learning in Quality Improvement (from previous year) - Please outline what this year has contributed to your development and knowledge of QI

Prior to this year I had limited exposure to QI. I attempted to start a QIP in ST5 at Whittington NHS Trust, but the subject – SVT – turned out to be a non-starter and at that stage I had less understanding of QI methodology.

I feel like I have gone on an important journey. The process of unpacking a problem and dividing into its component parts, then constructing a SMART aim with targeted, measurable potential solutions was enormously rewarding. It felt like I "switched the lights on". I am indebted to Dr. MM, Dr. TP and Dr. ~ß for their QI coaching.

I have done plenty of previous audit work and contributed as a team member to QI work others have led on - notably last year I ran a series of multi-disciplinary in-situ simulations to embed a new Major Haemorrhage protocol into hospital culture. I therefore contributed to a single PDSA cycle.

This was my first real taste of leading a QIP. I identified a problem I truly cared about, co-ordinated my own team, and introduced effective interventions that appear to have changed the educational culture of my department. I am immensely proud of the work we have done here.

It is worth noting that I used some excellent online resources including Life QI, the IHI, the RCEM Quality Improvement Guide, and NHS Improvement. I also attended a virtual training day hosted by Dr. AKM (London EM QI lead) in June 2021.

3.3 – Personal Development

Longitudinal learning in Quality Improvement (future years) – Please describe your plans for the next stage of your career in QI. What do you hope to learn/achieve? How do you hope to contribute to improving patient care?

I have no doubt that I will be pursuing further QI work in the near future. I am due to CCT in June 2022, followed by a year-long fellowship with Sydney HEMS from August 2022. My plan is to lead on an educational QIP in Sydney (who have an impressive educational programme) in the first instance.

My more medium-term ambition is to lead on an educational QIP as an EM consultant with similar themes to this project, but perhaps with a loftier SMART aim. I feel such a strong sense of reward from this experience that I would consider pursuing the role of departmental QI lead in the future.

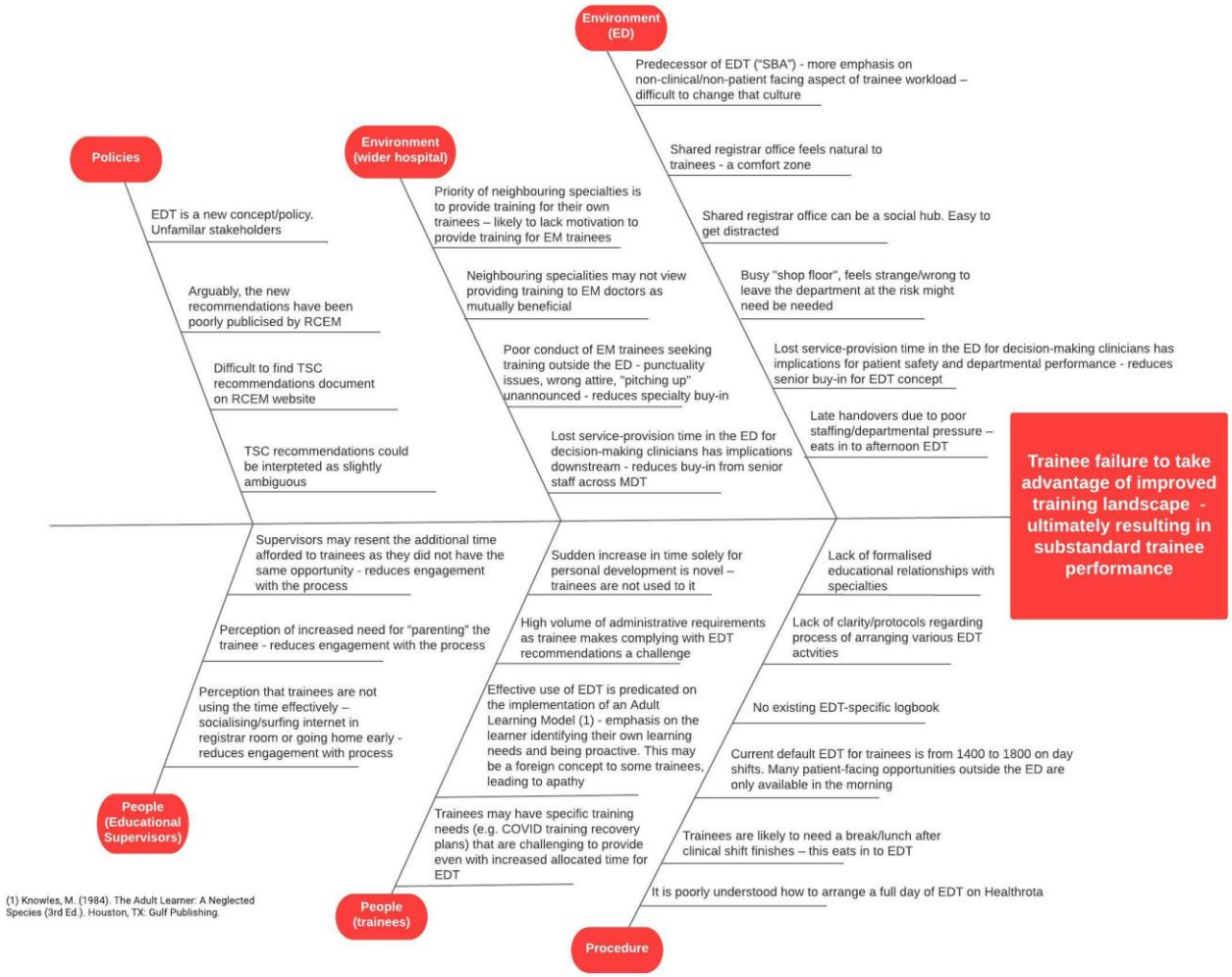
References

1) RCEM Training Standards Committee EDT Recommendations. May 2021.
2) Plan, Do, Study, Act (PDSA) Cycles and the Model For Improvement> NHS England and NHS Improvement. January 2021.
3) East London NHS Foundation Trust QI website – "Run Charts".
4) RCEM Quality Improvement Guide. June 2020.

APPENDICES

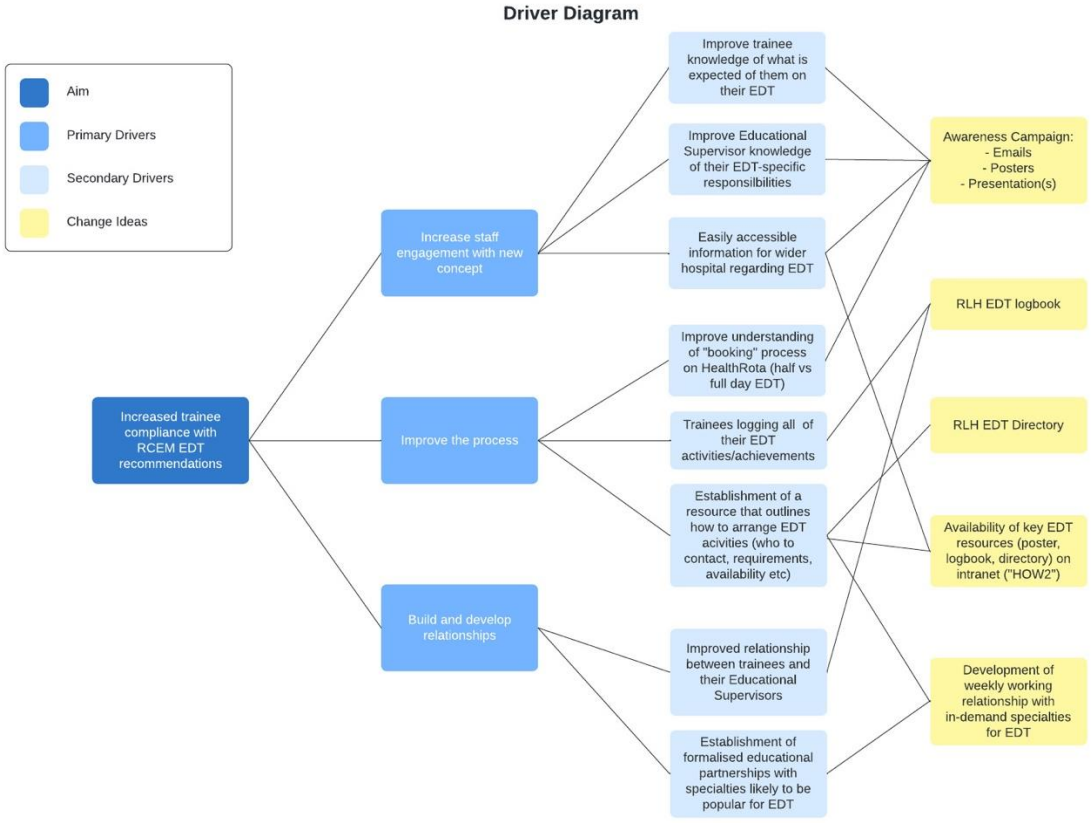
These files should be uploaded to a folder in your documents section in Kaizen Link to them in the main QIAT form

Appendix 1



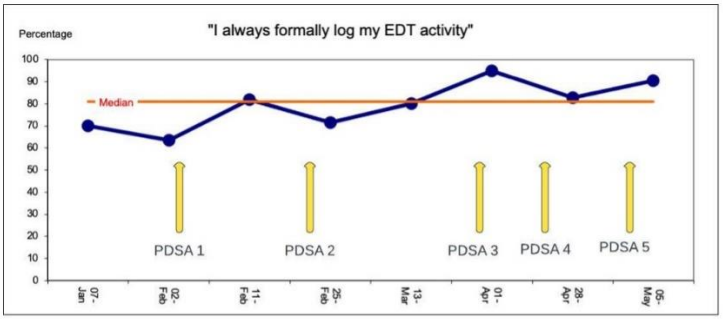
(1) Knowles, M. (1984). The Adult Learner: A Neglected Species (3rd Ed.). Houston, TX: Gulf Publishing.

Appendix 2

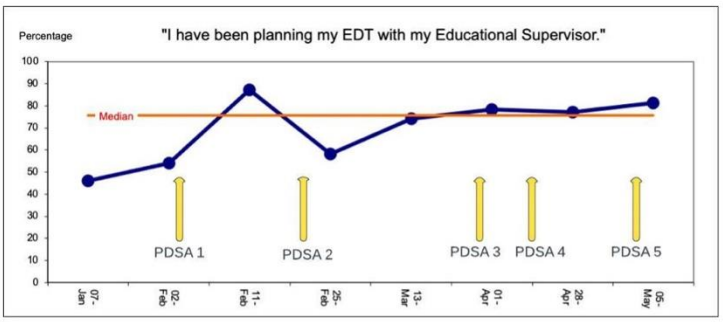


Appendix 3

RCEM TSC recommendation: **All EDT activity should be logged.**
- Baseline: 70%
- Post-PDSAs: 90.6%

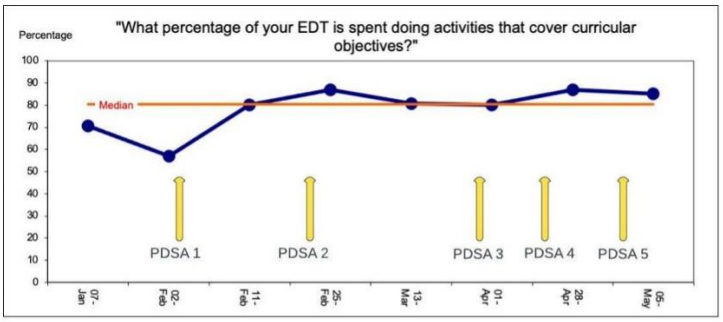


RCEM TSC recommendation: **All trainees should be making an EDT PDP with their ES.**
- Baseline: 46.1%
- Post-PDSAs: 81.3%



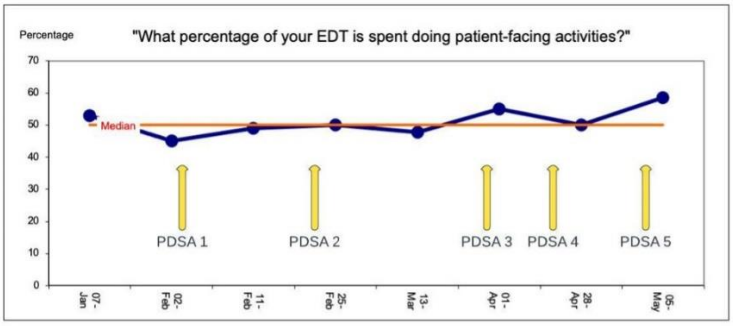
RCEM TSC recommendation: **All EDT activities should be covering curricular objectives.**

- Baseline: 70.7%
- Post-PDSAs: 85.3%

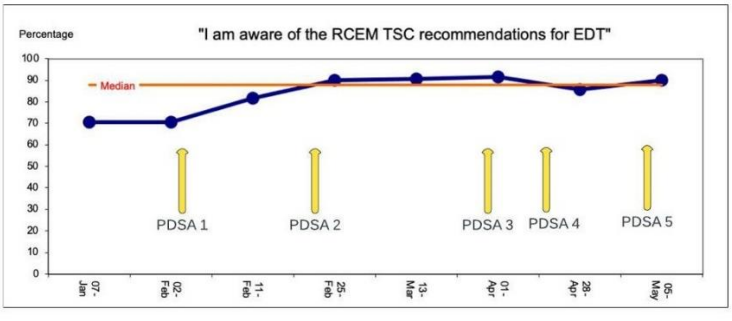


RCEM TSC recommendation: **50% of EDT activity should be patient-facing.**

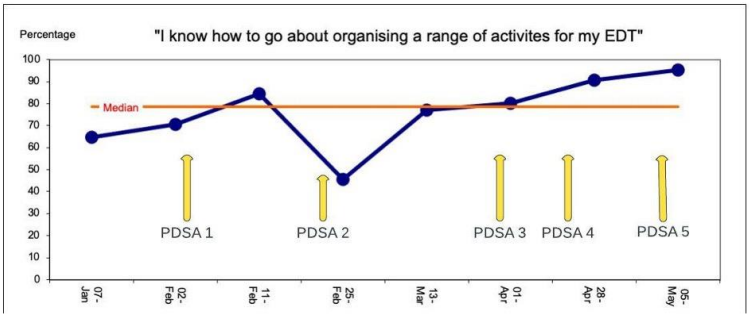
- Baseline: 53%
- Post-PDSAs: 58.6%



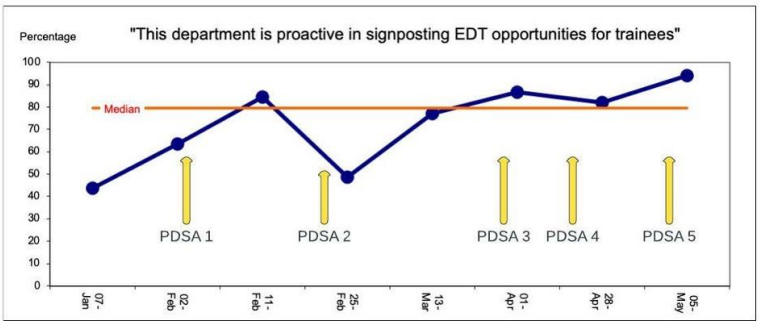
Process measure 1: **Trainee awareness of RCEM TSC recommendations**



Process measure 2: **Trainee awareness of how to organise a range of EDT activities**



Process measure 3: **Trainee perception of departmental proactivity in signposting EDT opportunities**



Appendix 4