NHS England

enhance National Presentation and Development Day Event Handbook

Wednesday 8th July 2026



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enhance National Presentation and Development Day overview and purpose

Welcome, and thank you for attending the first NHS England **enhance** National Presentation and Development Day, taking place on Wednesday 8th July 2026 at Cambridge Junction J3, Clifton Way, Cambridge CB1 7GX.

The Enhancing Generalist Skills, or **enhance**, programme was developed in response to the Future Doctor (2020) report, which highlighted the need for healthcare professionals to work confidently across complexity, uncertainty and changing population need.

Since roll-out began in 2021, **enhance** has grown into a national programme of learning, practice development and community building, supporting professionals to strengthen the generalist capabilities needed to deliver excellent, person-centred care across the health and care sector.

The programme has reached a wide range of professionals, including doctors, dentists, pharmacists, nurses, allied health professionals, public health colleagues, managers, educators and colleagues working in voluntary, community and social care settings. Its strength lies in bringing people together across professional, organisational and geographical boundaries, creating a shared language and community of practice around the challenges that matter most to patients, communities and services.

enhance is structured around six core domains: person-centred practice, complex multimorbidity, system working, population health, social justice and health equity, and environmental sustainability. Cross-cutting themes of leadership, wellbeing, digital innovation and transformative reflection encourage learners to look beyond individual episodes of care and consider how services, systems and communities can work together to improve outcomes and reduce avoidable harm, duplication and inequality.

The **enhance** National Presentation and Development Day brings together people with a shared interest in improving healthcare to exchange learning and celebrate the work taking place across health and social care. The presentations and posters in this handbook show how enhance principles are being applied in practice: redesigning pathways, improving patient experience, strengthening multidisciplinary working, advancing population health, and embedding sustainability and health equity within service improvement.

As **enhance** continues to evolve, this event offers a space to recognise progress, learn from one another and strengthen the national community of practice that has developed around the programme. We encourage delegates to reflect on how others' work connects with their own practice and how ideas might be adapted locally. By bringing together varied skills, experiences and knowledge, the day offers a valuable opportunity to broaden perspectives, build connections and support collaborative improvement across the system.

Key Delegate information

Poster Presentation logistics

- Poster size specifications should align with the details below:
    - Height: 1189 mm
    - Width: 841 mm
    - Orientation: Posters can be either portrait or landscape within the size parameters above, as per your preference.
        - For reference, maximum poster sizes are based on A0 paper in portrait orientation.
        - If you prefer/have designed a landscape poster, based on standard “A class” paper sizes this would need to be A1 size (height 594mm, width 841mm).
- Poster presentations will take place in the dedicated poster space (J3). We kindly encourage all poster presenters to engage with and support other presenters by viewing and listening to posters during the allocated sessions.
- Short oral presentations will run concurrently in the main room (J2). Should you wish to enter the main room during these sessions, we kindly ask that you do so quietly to avoid disrupting presenters.
- Please note that poster judges will review each poster and will invite you to present/discuss your work. These discussions will be limited to a maximum of three minutes, and timings will be strictly adhered to.

On the day

- **You are required to bring a printed copy of your poster for display on the day of the event.**
- Where posters have been submitted digitally, they will be viewable here for up to 14 days following the event.
- You will be provided with a QR code to display alongside your poster. This will enable delegates to leave feedback or ask questions if you are not present. If you have opted to receive feedback automatically, it will be sent to you as it is collected. Otherwise, we will collate all feedback and provide it within 14 days of the event.

Oral Presentation logistics

- Short oral presentations will take place in the main room (J2)
- Poster presentations will run in parallel in room (J3)

- We encourage all attendees to use the breaks to view posters and network with colleagues

On the day

- Presenters will be allocated a seat at the start of each session
- Please report to the event team a few minutes before your session begins so you can be directed accordingly
- You will be asked to stand to the side of the stage when the previous presenter reaches their 8-minute mark, so that the session runs smoothly

Timing

- Presentation time: maximum 8 minutes (strictly enforced)
- Q&A: up to 2 minutes (also strictly timed)

Feedback and Certificates

Attendees can provide feedback directly to poster and short oral presenters.

Each poster presenter will be given a QR to display alongside their poster. Attendees can use this to provide comments or feedback. A single QR code will enable delegates to provide feedback or comments directly to short oral presenters. It will be displayed regularly throughout the day. You can also use this link:

To help us continually improve the organisation and planning of these events, it is important we gain your feedback from the day. After the event, you will be emailed a link to complete a feedback survey. A certificate of attendance will be emailed to you upon completion of this feedback survey.

All presenters will be issued a certificate confirming their presentation. Please note that these will take approximately 14 days to arrive following the event.

We have worked hard to put together what we feel will be a great event and we hope you have an enjoyable and informative day.

Event programme

Time	Room	Item	Lead
08:40 – 09:15		Registration, Tea & Coffee	
09:15 – 09:30	J2	Welcome, housekeeping and opening remarks	The East of England Enhance Team
09:30-10:30	J2	**Short oral presentations 1: enhance programme - development & outcomes (6)** - ID 52: Applying Enhance principles to real life: the development of applied Enhance modules - ID 73: Creating space for reflection: Peer-led implementation of Enhance person-centred practice teaching in foundation training - ID 46: "Stepping outside of our comfort zone": learning through multi-professional shadowing in the NHS - ID 15: Development and Evaluation of a Regional Perioperative Medicine Training Day within the Enhance Enable Programme - ID 109: Evaluating the Real-World Impact of an Innovative Multiprofessional Generalist Leadership Programme - ID 29: What happens after Enhance? Multi-professional alumnus outcomes across the North East and Yorkshire.	Presentation judges: Praveen Ande + 1 TBC Timekeeper: Emily Robinson
09:30-10:30	J3	**Poster presentations 1: digital innovation and pathway redesign (18)** - ID 131: Radiology reports and patient understanding: a narrative review of plain-language communication, health literacy and implications for patient-centred care - ID 65: Endorsing Results in Digital Health Records – are we Cerntain? - ID 59: AI Chatbot vs Policy Hub for Accessing Clinical Guidelines: A Proof-of-Concept Quality Improvement Study - ID 53: Evaluation of an AI-Assisted Documentation Tool in the Emergency Department: A Single-Centre Study of Accurx Scribe - ID 27: Restoring structured communication in digital handovers: Improving SBAR quality on a clinical messaging platform - ID 66: OT Draw: Clinician Led Digital Innovation to Improve Housing Adaptations, Workforce Capacity and Patient Experience	Poster judges: TBC Timekeeper: Elizabeth Maul

		- ID 121: Improving the Final Handover: A Multi-Stakeholder Quality Improvement Initiative to Improve Discharge Letter Safety, Quality, and Timeliness - ID 45: Optimising emergency department flow through early senior clinical decision-making: a quality improvement evaluation of the See and Sort Stream Initiative (SaSSI) at Royal Preston Hospital - ID 36: Implementing Patient-Initiated Follow-Up (PIFU) in Community Mental Health Teams: A Quality Improvement Project - ID 117: Optimising resident doctor reviews on the postnatal ward: A Quality Improvement Project - ID 85: Urine Culture Microscopy Rejections in ED: The importance of communication across teams - ID 102: Post-Operative Dietary Advice: A QIP to Improve Ward Team Knowledge and Practice - ID 129: Evaluating the Impact of Care Home Ward Rounds on Deprescribing, Advance Care Planning, and Unplanned Admissions: A Quality Improvement Project - ID 118: FIT For Frailty? A novel geriatric service delivering patient-centred care to elderly patients referred to the 2WW Lower GI Pathway - ID 70: Review of annual diabetic reviews for Type 2 diabetics under the age of 40 years old in the Orchard practice as of April 2026. - ID 98: Bone Scintigraphy Use in Prostate Cancer Staging: Reflective Practice Towards an Environmentally Sustainable National Health Service (NHS) - ID 67: Reducing CT imaging of low-risk transient ischaemic attack patients in an emergency setting: quality improvement project with introduction of guideline - ID 96: Improving Compliance with Head-of-Bed Elevation Guidelines in Mechanically Ventilated Patients: A Quality Improvement Project	
10:30 – 10:50		**Refreshment break, networking, poster viewing**	

10:50 – 11:30	J2	**Keynote speaker session 1**: Professor Dame Jane Dacre *This talk will explore the case history of a patient with complex comorbidity in the context of the Enhance Programme. The specific management of a patient is sometimes difficult to reconcile into the broader healthcare agenda.*	Professor Dame Jane Dacre
11:40 12:40	J2	**Short oral presentations 2: social justice, health equity and population health innovations** - **ID 119**: Strengthening Primary Care Engagement for People Seeking Asylum in Temporary Accommodation: A Quality Improvement Pilot Using a Thinking Space Approach - **ID 105**: Improving the Management of LGBT Patients Through Online Healthcare Education: A Quality Improvement Project - **ID 126**: Using Community Health and Wellbeing Workers to Improve Uptake of Asthma Reviews for Children in Socio-economically Deprived areas: A Quality Improvement Project - **ID 63**: Crisis Connect Network: A Digital Platform Approach to Health Equity in East Yorkshire - **ID 51**: Breast reconstruction and learning disability: the lack of easy read resources - **ID 136**: 'Was Not Brought' (dental safeguarding pathways for children and adults who rely on carers to bring them to appointments)	Presentation judges: TBC Timekeeper: TBC
11:40- 12:40	J3	**Poster presentations 2: clinical quality, safety and sustainability (19)** - **ID 61**: Building MDT confidence in recognising deterioration in dementia patients: a ward-based audit and educational quality improvement project - **ID 103**: Simtegrated Care: A Novel Cross-Sector Simulation Model to Improve Systems-Based Understanding and Interprofessional Learning in Early Clinicians - **ID 81**: On Time, Every Time: Improving Timely Administration of Parkinson's Disease Medications - **ID 106**: Improving Early Recognition of Postoperative Delirium in Older People in PACU: A Quality Improvement Project - **ID 99**: Improving equity in urine drug screening on a general adult female psychiatric ward - **ID 56**: Improving early fluid resuscitation in Acute Pancreatitis - **ID 23**: Audit on the Post-operative Use of Prophylactic Topical Antibiotics Following Cataract Surgery	Poster judges: Catherine Gouveia + 1 TBC Timekeeper: TBC

		- ID 83: Getting It Right the First Time: Breast Day Case Audit - ID 38: Time to stop stooling: Improving laxative prescribing in the older adult - ID 28: An Oncologist-Led Cardio-Oncology Service at Nottingham City Hospital: An Integrated Model for Cancer Care - ID 87: Irradiated Blood Transfusion QIP - ID 74: Improving ReSPECT Plan Quality in Palliative Inpatient Care - ID 116: Post-stroke depression QIP - ID 111: Improving Recognition and Continuity of Domiciliary NIV During Acute Hospital Admissions: A Quality Improvement project - ID 89: Greening Lean: Overcoming barriers to integrating environmental practices in surgical Lean management projects: A scoping review - ID 124: Perceived Sustainability of Severn Deanery Hospitals by Resident Doctors - ID 21: Reducing Screen Brightness to Improve Environmental Sustainability: An Eco Quality Improvement Project - ID 101: Implementation of a Waste Reduction Initiative in a Sexual Health Clinic: A Quality Improvement Project - ID 88: Addressing the climate emergency and a healthcare system in crisis; how can we optimise the blood culture pathway in microbiology to support healthcare sustainability?	
12:40 – 13:30		**Lunch, networking, poster viewing**	
13:30 - 14:00	J2	**Keynote speaker session 2**: Professor Beverley Harden	Professor Beverley Harden
14:05 – 15:15	J2	**Short oral presentations 3: innovative ideas and doing things differently: environmental sustainability, system working and digital pathways (7)** - ID 14: Bring Your Own Tupperware (BYOT): A Multiprofessional Quality Improvement Initiative to Reduce Healthcare Waste - ID 13: Walking Aid Recycling Project	Presentation judges: TBC Timekeeper: TBC

		- ID 49: “Would I start this today?” Reframing Repeat Prescribing as a Real-Time Environmental Intervention - ID 40: Digital Self Scheduling: A Service Improvement Project for Clinic Optimisation in Outpatient Physiotherapy - ID 76: Improving Advanced Care Planning Through Standardised Documentation and Staff Education: A Quality Improvement Project - ID 100: Transforming care for older adults with heart failure, frailty and complex multimorbidity: co-development of a holistic multidisciplinary pathway - ID 79: From Innovation to Impact: AI-enabled Decision Support in NHS Clinical Pathways	
14:05–15:15	J3	**Poster presentations 3: learning, leadership and inclusion (15)** - ID 12: Enhance in Undergraduate Medical Education: a pilot programme - ID 80: Is VR a Useful Tool in Developing Communication Skills in Foundation Doctors? - ID 128: The North Mid Enhance programme – development of live teaching sessions (3 cycles) - ID 68: Improving multi-professional understanding of complex multimorbidity: 'Making it real - ID 11: Snakes and Ladders as a method for interprofessional Population Health learning - ID 125: The ALiHN Model: A Community-Led Approach to Early Career Professional Development - ID 130: Attitudes towards the use of Artificial Intelligence (AI) in Paediatric Healthcare, Insights from parents, carers, children and young people: A cross-sectional survey study - ID 77: Structured “Speak-Up” sessions: Promoting wellbeing and psychological safety for Obstetrics and Gynaecology (O&G) Residents - ID 55: Beyond Borders, Beyond Boundaries: Empowering Allied Health Professionals Internationally to Transform Community Palliative Care - ID 26: Difficult Conversations Under Pressure: A Communication Toolkit for Doctors (CALMER)	Poster judges: TBC Timekeeper: TBC

		- ID 110: A trust-wide resident doctor wellbeing initiative to procure and distribute Patagonia fleece jackets: a quality improvement report - ID 78: Blankets for Ipswich - connection, creativity, community - ID 39: Reducing Sex Inequity in Cardiac Rehabilitation: Implications for Multiprofessional Learning and Service Redesign - ID 35: Promoting patient-centred Parkinson's Disease practice – upskilling knowledge and confidence on an inpatient ward	
15:15 – 15:40		**Refreshment break, networking, final poster viewing**	
15:40 – 16:00	J2	Reflections on enhance and your achievement today	Tahreema Matin
16:00 – 16:45	J2	**Keynote speaker session 4:** Professor Chris Whitty: *Where is medicine going?*	Professor Chris Whitty
16:45 – 17:00		Prizegiving and closing remarks	The East of England Enhance Team
17:00		**Close (and more networking if time allows)**	

Keynote Presentations and Guest Speakers

Keynote Speaker 1:
Professor Dame Jane Dacre DBE, MD, FRCP
(10:50 – 11:30)

Dame Jane is the lead of the Medical education and Training Review Phase 2. She is Emeritus Professor of Medical Education at UCL, and a specialist advisor to parliament on the Health and Care Committee, where she chairs an Expert Panel, responsible for evaluation Government Pledges. She is the President of the Royal Medical Benevolent Fund, and President of the Medical Womens Federation. She is the immediate past President of the Medical Protection Society She was the lead for the Department of Health and Social Care review of the Gender Pay Gap in Medicine, with Professor Carol Woodhams from Surrey University Business School. This review 'Mend the Gap: The Independent Review into Gender Pay Gaps in Medicine in England' was published in December 2020 and she now chairs the DHSC gender pay gap implementation advisory group. She was the co- chair of the Commission on Professional Leadership in Pharmacy, published in 2023 and is leading an independent review into the Prescribing Skills Assessment for the Medical Schools Council.

Jane is the former Director of UCL Medical School and honorary consultant physician and rheumatologist, at Whittington Health in London. She is past president of the Royal College of Physicians of London, only the third woman to hold that position in the College's 500 year history. Her research is in medical education, assessment, gender, and equality in healthcare.

Keynote Speaker 2:
Professor Beverley Harden, MBE, FCSP
(13:30 – 14:00)

Beverley is currently Deputy Chief AHP Officer within NHS England, she is the lead for allied health workforce and education and leads the national multiprofessional advancing practice programme.

Beverley is currently completing a Churchill Travelling Fellowship investigating rural, coastal and underserved area AHP workforce issues. A key recommendation of this work is that the enhance programme be supercharged across the career spectrum. Enhance can drive aspirational roles and training within challenged health economies, ensuring leaners across all professions are able to develop the social justice calling that brought them into health care. To date, this has not been successfully harnessed - through to system leaders and all of us in

between. Building community and health through to supporting positive participation in education and work is a team sport. A team sport which can change life chances, fuel wellbeing and invigorate communities.

Today we meet as that team each playing our part, working as one with respect, trust and understanding being at the heart of what we do; working within, alongside and for the communities we serve driven by what matters to them.

Keynote speaker 3: Professor Chris Whitty (16:00 – 16:45)

Professor Chris Whitty is Chief Medical Officer for England, the UK Government's Chief Medical Adviser and head of the public health profession. He is also a practising NHS Consultant Physician at University College London Hospitals and the Hospital for Tropical Diseases.

An epidemiologist by background, Professor Whitty has worked and conducted research across the UK, Africa and Asia. He previously served as Chief Scientific Adviser at the Department of Health and Social Care, with responsibility for the department's research and development, and has held senior scientific leadership roles across government, including during major public health emergencies.

Poster and Oral Presentations

All abstract submissions accepted for this presentation day are listed below in submission number order. Thank you to everyone that submitted abstracts. The team hope that this day is as much a celebration of your personal achievement for being selected as it is to appreciate the work of colleagues from across the system.

Submission ID: 11

Title: Snakes and Ladders as a method for interprofessional Population Health learning

Presented by: Fiona Tilsed, Student Volunteer; Helen Cattermole, Enhance Programme Lead; North East and Yorkshire

Poster presentation section 3: 14:05 - 15:15 learning, leadership & inclusion

Affiliation to enhance: Non-clinical student volunteer on enhance
Relevant enhance domains: Population health; Social justice and health equity
Relevant enhance cross-cutting themes: Wellbeing

Fiona Tilsed(1), Ben Elliott (2), Kate Elliott (3), Mohamed Malik (4), Helen Cattermole (5)

(1) Undergraduate student, University of Cambridge; (2) Postgraduate student, University of York; (3) Social Prescriber and postgraduate student, University of York; (4) Enhance TPD Yorkshire & Humber, NHS England; (5) Head of Generalist School Yorkshire & Humber, NHS England

Introduction

For learners used to dealing with individual patients or those with no direct patient contact, population health can feel like a theoretical concept. We wanted to investigate whether presenting case studies in a game-based format stimulated discussion and made the content accessible even to non-clinical learners.

Using games within interprofessional undergraduate education improves engagement, communication and knowledge sharing (1). For postgraduates, gamification is helpful only when the relevance of the approach is clearly seen as part of the learning ‘journey’ (2). Health-related board games are effective in increasing knowledge in an efficient manner (3), but there is very little published about engaging interprofessional postgraduate groups with board games designed to teach population health concepts.

Methods

A novel teaching game, based on the traditional ‘Snakes and Ladders’ was designed to stimulate interactive discussions and deepen understanding of population health issues amongst interprofessional learners (both clinical and non-clinical) on the Enhance programme. It was piloted as a tabletop version before being rolled out to larger groups of learners in a floor-based game. Feedback was obtained from each group of learners both immediately and at the end of the Enhance programme a few months later.

Results

Participants enjoyed the game, and the competitive element brought an aspect of fun into a topic that many learners find challenging. The simple construct allowed full participation by all learners, even those from a non-clinical background with no prior knowledge of population health. The game construct allowed the topic to be delivered by non-specialist faculty. Qualitative evaluation shows that participants were engaged and enthused by the discussion. The learning was transferred to other modules within the Enhance programme, and concepts were retained by participants.

Discussion/Conclusion

Utilising simple games can enhance participant learning of population health concepts in mixed interprofessional groups. The approach is fun and promotes engagement even from non-clinical learners. Some participants were so inspired by the game that they used similar game formats to reflect on their learning in poster format. We are now piloting an online version for delivery to larger audiences and/or online teaching sessions.

References

1. Aynsley, S et al (2022) Pedagogic development of a gamified approach to enhancing engagement in interprofessional education. Compass: Journal of Learning and Teaching in Higher Education, 15(1), pp1-9
https://journals.gre.ac.uk/index.php/compass/article/view/1178

2. Oliver, LA; Manning-Stanley, A; Bridge P (2024) Implementing gamification within interprofessional learning: perspectives of Higher Education staff and students, Cogent Education, 11:1, 2423717 pp1-19
https://www.tandfonline.com/doi/full/10.1080/2331186X.2024.2423717

3. Gauthier A et al (2019) Board Games for Health: A Systematic Literature Review and Meta-Analysis. Games for Health Journal 2019 8:2, 85-100
https://journals.sagepub.com/doi/epub/10.1089/g4h.2018.0017

Submission ID: 12

Title: Enhance in Undergraduate Medical Education: a pilot programme

Presented by: Helen Cattermole, Head of Generalist School Yorkshire & Humber, NHS England and honorary Senior Lecturer Hull York Medical School; Antigone Lee, Undergraduate enhance SSIP Participant; Bina Kader, Undergraduate enhance SSIP Participant; North East and Yorkshire

Poster presentation section 3: 14:05 - 15:15 learning, leadership & inclusion

Affiliation to enhance: Head of enhance programme; Student participant on enhance
Relevant enhance domains: Environmental sustainability; Social justice and health equity; System working
Relevant enhance cross-cutting themes: Wellbeing; Leadership

Helen Cattermole (1), Evie Handel (2), Bina Kader (3), Antigone Lee (4), Paul Whybrow (5)

(1) Head of Generalist School Yorkshire & Humber, NHS England and honorary Senior Lecturer Hull York Medical School; (2/3/4) Undergraduate student; (5) Senior Lecturer; Hull York Medical School

Introduction

There is increasing evidence that medical training needs to move towards a more generalist approach to accommodate the increasing needs of complex multi-morbid patients in a changing healthcare environment (1) (2). The Enhancing Generalist Skills (Enhance) programme (3) was developed to grow these skills in early-years medical professionals and, increasingly, in multi-professional health and care colleagues across the UK. Expanding this offer to undergraduates is complicated, due to the challenges of finding time for delivery within the existing curriculum.

Methods

Hull York Medical School (HYMS) students undertake a student-selected scholarship and special interest programme (SSIP) in their fourth year. Building on work done at Peninsula and Exeter Medical Schools, in 2025-26 we offered students a SSIP generalist module, based around the multi-professional Enhance programme. Students were encouraged to attend Enhance sessions and learn alongside established health and care professionals and to choose elements of the programme for further research and reflection, culminating in a summative poster and oral presentation.

Results

Three students undertook this pilot and attended Enhance sessions on complex multi-morbidity, environmental sustainability and systems working. They developed projects in different areas of interest (interprofessional learning, environmentally sustainable clinical skills practices, and barriers to healthcare in rural areas) and presented these to HYMS staff who were not involved in the project. Feedback from the students was overwhelmingly positive and the presentations sparked interest and support for generalist skills training from academic staff. The Enhance participants were supportive of the students attending and offered practical help and resources for the student projects.

Discussion/Conclusion

This pilot demonstrated the feasibility of offering generalist skills as part of the SSIP and gave the students insights into health and care which were not covered elsewhere in the curriculum. The offer is being expanded for 2026-27 so that more students can undertake this learning.

References

1. https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2023-health-in-an-ageing-society

2. https://www.england.nhs.uk/publication/the-medical-training-review-phase-1-diagnostic-report/

3. https://www.hee.nhs.uk/our-work/enhancing-generalist-skills

Submission ID: 13

Title: Walking Aid Recycling Project

Presented by: Laura Baker, AHP Faculty Lead (Norfolk and Waveney)

Short oral presentations session 3: 14:05 - 15:15 innovative ideas and doing things differently: environmental sustainability, system working and digital pathways

Affiliation to enhance: Not affiliated
Relevant enhance domains: Environmental sustainability
Relevant enhance cross-cutting themes: Transformative reflection

The Norfolk and Waveney AHP Faculty have worked with our local prison and County Council to establish a walking aid recycling project. The project ensures that patients return any crutches, walking frames and metal walking sticks to their local recycling centre. They are then taken to HMP Norwich, where they are cleaned and refurbished (to NHS standards) by prisoners who work in the workshops. There are then regular deliveries made by the prison workshop supervisor back to the acute hospitals.

In the first year of the project, we saved £21.5k and reduced our collective carbon footprint by 19.5 tonnes of CO2 emissions (equivalent to driving around 35,000 miles).

Submission ID: 14

Title: Bring Your Own Tupperware (BYOT): A Multiprofessional Quality Improvement Initiative to Reduce Healthcare Waste

Presented by: Aya Hammad, Foundation Year 1 Doctor, South West

Short oral presentations session 3: 14:05 - 15:15 innovative ideas and doing things differently: environmental sustainability, system working and digital pathways

Affiliation to enhance: Current enhance fellow
Relevant enhance domains: Environmental sustainability; System working
Relevant enhance cross-cutting themes: Transformative reflection**;** Leadership

Healthcare systems contribute significantly to environmental harm, with single-use food packaging representing a visible and modifiable source of waste. There is a need for practical, workforce-led sustainability interventions embedded within everyday healthcare environments.

This quality improvement project describes the design and early implementation of a Bring Your Own Tupperware (BYOT) scheme at the Royal Devon and Exeter Hospital. The project aimed to reduce single-use packaging while supporting multiprofessional learning in sustainable practice and system-based working.

A stakeholder-informed approach was used, involving catering services, infection prevention and control (IPC), sustainability teams, and frontline staff. The intervention enables staff to bring reusable containers for takeaway meals, supported by co-designed safeguards addressing food safety and operational workflow. Behavioural strategies included visible prompts (posters in clinical areas, staff messes, and canteens) and a financial incentive (50p discount per meal).

Evaluation focused on feasibility, acceptability, and early impact. Initial data suggest an approximate 25% increase in uptake of reusable container use following implementation, although further data collection is ongoing. Process measures include BYOT transactions, while outcome measures include estimated reductions in single-use packaging and associated carbon savings (0.04–0.12 $kgCO_2e$ per container avoided). Qualitative feedback from staff and catering teams is informing iterative improvement.

Key learning highlights the importance of multiprofessional collaboration, leadership support, and simple behavioural nudges in embedding sustainable practice. Addressing practical concerns (e.g. IPC and workflow) was critical to feasibility.

While longer-term outcomes are pending, the project demonstrates a clear, scalable pathway to environmental and population health benefit, alongside improved sustainability awareness among staff. This low-cost intervention is transferable across healthcare settings.

Submission ID: 15

Title: Development and Evaluation of a Regional Perioperative Medicine Training Day within the Enhance Enable Programme

Presented by: Michael Barrett, Core Trainee / ST1-ST3 Doctor, East of England

Short oral presentations session 1: 09:30 – 10:30 enhance programme development & outcomes

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working; Population health; Complex multimorbidity
Relevant enhance cross-cutting themes: Leadership

Background

Perioperative care involves coordinated, multidisciplinary management of patients from the point surgery is first considered through to full recovery. High-quality perioperative care enhances the patient experience, including both satisfaction and standard of care, improves population health outcomes such as return to home or work and overall quality of life, and reduces healthcare costs by delivering greater value [1]. Acute medical conditions are a leading cause of surgical cancellations [2], highlighting the need for improved perioperative pathways. The Centre for Perioperative Care promotes multidisciplinary team (MDT) working to support these aims.

Despite this, formal perioperative training opportunities remain limited outside anaesthetic and surgical pathways. The Enhance Enable programme is an ideal platform to address these common goals and knowledge gaps by strengthening generalist and system-based skills across the NHS workforce, especially in early carer doctors.

Aim

To design and evaluate a regional, multiprofessional preoperative medicine training day that supports generalist skill development, system working, and leadership capabilities.

Context

We developed a hybrid training day combining lectures and interactive workshops. Faculty included clinicians from anaesthesia, medicine, nursing, and NHS management. Aimed mainly at early year doctors in training, local employed doctors and SAS doctors but open to all professionals.

Evaluation and Results

Evaluation was conducted using post-course surveys. Quantitative ratings and qualitative free-text feedback were analysed.

The 2025 & 2026 course received an overall rating of 9.2/10 & 8.8/10, with all participants agreeing it met their learning objectives. Attendees reported improved understanding of perioperative risk assessment, MDT working, and patient-centred decision-making.

Following the 2024 pilot, participant feedback has been used to refine the programme, including enhanced focus on MDT assessment and practical perioperative decision-making.

Sustainability

The programme is low-cost, utilises existing faculty, reproducible across regions and aligns with national Enhance domains.

Learning Points

Structured perioperative teaching addresses gaps in generalist training. MDT-focused education strengthens system working and patient care. Feedback-driven design improves educational quality. Regional training initiatives can support leadership development in complex care pathways.

[1] Centre for Perioperative Care. CPOC [Internet]. London: CPOC; [cited 2026 Apr 30]. Available from: https://cpoc.org.uk/about-cpoc

[2] Bedford J, McCone E, Hunt A, Warwick E, Moppett I, Belete M, et al. The Postponement and Cancellations in Elective Care study: a national evaluation of case postponements and cancellations in elective surgical pathways. Br J Anaesth. 2026;doi:10.1016/j.bja.2026.01.046.

Submission ID: 21

Title: Reducing Screen Brightness to Improve Environmental Sustainability: An Eco Quality Improvement Project

Presented by: Tommy Li, Foundation Year 2 Doctor; Emily Balls, Foundation Year 2 Doctor; South West

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: Environmental sustainability; System working
Relevant enhance cross-cutting themes: Wellbeing; Digital

Background

North Bristol NHS Trust (NBT) aims to reach net zero by 2030, but reported approximately 90,000 tonnes of CO_2 emissions in 2022–23. Computers are used constantly across clinical and non-clinical areas, so reducing screen brightness may provide a simple, low-cost way to reduce energy use. This registered audit/quality improvement project at Southmead Hospital, NBT QI ID: QI87644, aimed to estimate the energy, carbon and financial savings from reducing ward computer screen brightness.

Methods

Twelve stationary and mobile computers were sampled on Southmead Hospital wards 28a and 28b between January and March 2025. Baseline screen brightness and energy consumption were measured using a Mecheer LCD energy monitor. Brightness was then reduced to 40%, and energy use was remeasured after 12 hours. Energy reductions were converted into CO_2 and cost savings using NBT tariffs of 0.20705 $kgCO_2e$/kWh and £0.22/kWh. Findings were extrapolated across inpatient wards, excluding ED, SDEC, ITU and theatres. Resident doctors were also surveyed about the acceptability of reducing screen brightness and any screen-related symptoms.

Results

Median baseline brightness was 80% on ward 28a and 70% on ward 28b. Across both wards, reducing brightness to 40% saved an estimated 2.040 kWh/day, equivalent to annual savings of 744.6 kWh, 154.1 $kgCO_2e$ and £163.80. When extrapolated across inpatient wards,

estimated annual savings were 9,961.9 kWh, 2,062.6 kgCO_2e and £2,191. Fifteen resident doctors responded to the survey: 8 were positive, 4 were neutral and 3 were negative about reducing brightness. Six reported screen-related ocular symptoms, including eye strain, dryness and pain.

Conclusion

Reducing screen brightness is a simple, minimally disruptive digital sustainability intervention with measurable energy, carbon and financial benefits. Although the estimated savings are modest in the context of NBT's overall emissions, the project demonstrates a scalable behavioural and systems-level change. Further long-term data collection and PDSA cycles should assess whether brightness remains at 40%, will the reduction affects staff experience, whether lower brightness thresholds are acceptable, and how can unnecessary screen use can also be reduced.

Governance

This was a registered audit/QI project at Southmead Hospital. No patient-identifiable information was collected.

Reference

North Bristol NHS Trust. Annual Report and Accounts 2023–24.
Royal College of Emergency Medicine. GreenED QIP Starter: Monitor Brightness. 2025.
NHS England. Delivering a Net Zero National Health Service. 2020.

Authors: Emily Balls, Isobel Austin, Tommy Wai Kei Li, James Cunliffe, Devan Mair

Submission ID: 23

Title: Audit on the Post-operative Use of Prophylactic Topical Antibiotics Following Cataract Surgery

Presented by: Gagandeep Sachdeva, Core Trainee / ST1-ST3 Doctor; Reddin Ahmed, Core Trainee / ST1-ST3 Doctor, Midlands

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: Environmental sustainability; Population health
Relevant enhance cross-cutting themes: Leadership

Background

Post-operative endophthalmitis is a rare but potentially sight-threatening complication of cataract surgery. The use of intracameral antibiotics is supported by strong evidence demonstrating reduced infection rates; however, the role of post-operative topical antibiotic prophylaxis remains unclear. Current National Institute for Health and Care Excellence (NICE) guidance highlights this uncertainty and calls for further high-quality evidence.

Aims

To evaluate post-operative outcomes in patients undergoing cataract surgery with or without topical antibiotic prophylaxis.

Methods

A retrospective audit was conducted of patients undergoing cataract surgery between 13 March 2025 and 11 September 2025 on a single consultant surgeon's list. Data were collected from electronic clinical systems (NerveCentre and MediViewer). Baseline demographics, comorbidities, intra-operative complications, and post-operative outcomes were recorded and analysed using Google Sheets. A total of 135 cases were identified, with 128 included following exclusion of incomplete datasets.

Results

Among the 128 analysed cases, intra-operative complications occurred in five patients, including two posterior capsular ruptures. Post-operative complications were observed in eight patients, including anterior chamber inflammation, macular oedema, punctate keratitis, and retinal pathology. No cases of post-operative endophthalmitis were identified. Notably, 110 of 128 patients did not receive post-operative chloramphenicol prophylaxis.

Conclusion

No cases of post-operative endophthalmitis were observed despite most patients not receiving topical antibiotic prophylaxis. These findings are consistent with a previous 2024 audit cycle. While limited by sample size and absence of events, the results support consideration of omitting routine post-operative topical antibiotics in patients receiving intracameral antibiotics.

Cataract surgery is the most commonly performed elective procedure in the NHS, with over 680,000 cases annually. With chloramphenicol 0.5% eye drops costing from £1.78 per unit, discontinuation of routine use could yield significant cost savings. Additionally, reducing unnecessary antibiotic use may lessen environmental impact and support antimicrobial stewardship. Further multi-centre studies are required to inform national policy and clinical guidelines.

Submission ID: 26

Title: Difficult Conversations Under Pressure: A Communication Toolkit for Doctors (CALMER)

Presented by: Karishma Vora, Foundation Year 1 Doctor, Midlands

Poster presentation section 3: 14:05 - 15:15 learning, leadership & inclusion pathways

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Leadership; Transformative reflection

Background

Communication failures in high-pressure clinical environments contribute to patient harm, conflict, and unsafe decision-making, particularly among vulnerable populations requiring family-centred care. Clinicians often encounter emotionally charged scenarios involving uncertainty, unrealistic expectations, and safeguarding concerns. Local feedback revealed inconsistent approaches and practical barriers, such as time constraints, lack of private space, medico-legal anxiety, and variable senior support. The project sought to enhance clinician confidence and provide structure for complex communication through a pragmatic, ward-ready toolkit.

Methods

A quality improvement project was implemented informed by paediatrics and geriatrics to design a concise digital communication toolkit. Baseline data were collected through a survey of 54 clinicians of varying grades, assessing confidence across nine challenging communication domains using a 5-point Likert scale, as well as perceived barriers and free-text feedback. The intervention consisted of a three-page digital pack delivered with teaching, incorporating a structured workflow checklist (T-SPACE), communication frameworks (CALMER), and a barriers resource (Privacy Ladder and CLEAR documentation guidance). Post-intervention evaluation repeated confidence measures and assessed uptake, usability, and feasibility in clinical practice.

Results

Baseline responses identified the lowest confidence in scenarios involving distressed relatives, unrealistic expectations, clinical uncertainty, safeguarding/capacity, and ceilings-of-

care discussions. Key barriers included time pressure and limited access to private space. Post-intervention responses (n=11) demonstrated uptake, with 45% reporting use of the toolkit in practice. Mean usefulness scores (1–5) were high: improved structure (4.73), clarity in communicating uncertainty (4.55), documentation quality (4.55), recommendation to others (4.64), and practicality under pressure (4.45). High confidence (≥4/5) was reported for documentation (91%) and escalation (100%). Respondents were resident doctors and registrars; representation in geriatrics was limited in the analysis.

Conclusions

This project demonstrates that a brief, structured communication toolkit is feasible and highly acceptable in acute clinical settings, with strong perceived benefits in communication clarity, documentation, and escalation. By addressing human factors and variability in clinician confidence, it provides a scalable approach to improving patient-centred communication and safety in complex, high-pressure scenarios. Further PDSA cycles will target wider specialty engagement and support integration into routine practice.

Submission ID: 27

Title: Restoring structured communication in digital handovers: Improving SBAR quality on a clinical messaging platform

Presented by: Marion Sadler, Foundation Year 1 Doctor, East of England

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working; Person centred practice
Relevant enhance cross-cutting themes: Digital; Leadership

Introduction

Effective communication is essential for patient safety, and failures contribute to adverse safety events.(1) SBAR (Situation–Background–Assessment–Recommendation) supports structured handover, but digital messaging can reduce communication quality (2). Following introduction of the Alertive app at Princess Alexandra Hospital, baseline analysis suggested SBAR compliance of 1.4% with miscommunication leading to omissions and near-misses. This project aligns with Enhance domains of Systems working and Person-centred practice, and cross-cutting themes of Digital and Leadership, addressing safe multiprofessional communication in evolving digital systems.

Objective

To improve the number and quality of SBAR handovers on a ward using a digital messaging platform.

Method

A two-cycle Quality Improvement Project analysed all handover messages sent to an out-of-hours ward role over two pre and post intervention 14-day periods. Messages were scored (0–4) based on inclusion of SBAR components. Interventions included:

- SBAR posters
- Lanyard cue cards
- 15-minute ward-based teaching with pre/post questionnaires.

This was conducted as a registered QI project with no patient-identifiable data.

Results

271 messages were analysed (143 pre, 128 post). Mean SBAR score improved by 39.5% (1.72 -2.40), and full compliance increased from 1.4% to 6.3%. All domains improved, particularly “Background” (141%). Improvement was greater out-of-hours (54.5%) than daytime (26.7%). Pre-intervention, 71.4% of staff reported using SBAR only “sometimes”; post-intervention, intention to consistently use SBAR rose from 28.6% to 100%. Confidence increased by 30%. Barriers included time constraints and confidence.

Conclusions

Low-cost, scalable interventions improved structured communication on a digital platform. This demonstrates that digital innovation must be supported by education and behavioural change to maintain safe, person-centred care. Improving SBAR use enhances shared understanding across multiprofessional teams, with a clear pathway to improved patient safety outcomes. Further work will focus on sustainability and wider implementation.

References

1. Müller M, Jürgens J, Redaèlli M, et al. Impact of the communication and patient hand-off tool SBAR on patient safety: a systematic review. BMJ Open 2018;8:e022202.

2. Haig KM, Sutton S, Whittington J. SBAR: a shared mental model for improving communication between clinicians. Jt Comm J Qual Patient Saf 2006;32:167-75.

3. Wu RC, Morra D, Quan S, et al. The use of smartphones for clinical communication on internal medicine wards. J Hosp Med 2011;5:553-9.

Submission ID: 28

Title: An Oncologist-Led Cardio-Oncology Service at Nottingham City Hospital: An Integrated Model for Cancer Care

Presented by: Navin Mathiyalagan, Higher Trainee Doctor, Midlands

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working; Complex multimorbidity; Person centred practice
Relevant enhance cross-cutting themes: Digital; Leadership

An Oncologist-Led Cardio-Oncology Service at Nottingham City Hospital: An Integrated Model for Cancer Care

Authors: Navin Mathiyalagan1, Muhammad Adeel Sarwar1, Lucy Gossage1, Jun Hao Lim1, Rahul Eric1, Daniel Yeo1, Maryam Alani1, Thomas Mathew2 , Professor Arjun K Ghosh3 .

1 Department of Oncology, Nottingham City Hospital.

2 Clinical Director for Cardiology and Consultant Cardiologist, Nottingham City Hospital.

3 Consultant Cardio-oncologist and Cardiologist, Barts Heart Centre and UCLH. Cardiology TPD, NE and NC Thames.

Service Improvement Initiative

Background / Problem:

Cancer therapy-related cardiovascular toxicity (CTR-CVT) causes significant morbidity and mortality. UK cardio-oncology services are often cardiology-led and separate from oncology workflows, risking fragmented care, delayed decisions, and treatment interruptions [1,2]. Nottingham City Hospital had no structured pathway. This initiative addresses Enhance domains of systems working, complex multimorbidity, and person-centred practice, with cross-cutting themes of multiprofessional working and leadership.

Ethics / Governance:

Registered as a service improvement initiative; formal ethics approval was not required. No patient-identifiable data included.

Aim:

To implement an oncologist-led, cardiology-collaborative service prioritising treatment continuity and cardiovascular safety.

Context:

A tertiary oncology centre, co-developed by oncologists, cardiologists, haematologists, nurses, and pharmacists.

What We Did:

We developed cardio-oncology guidelines covering immune checkpoint inhibitor (ICI) myocarditis, anthracycline and anti-HER2 (human epidermal growth factor receptor-2) cardiotoxicity, with standardised risk stratification and management. Unlike traditional symptom-triggered, cardiology-led models, this pathway embeds proactive surveillance. Baseline and serial troponin and B-type natriuretic peptide (BNP) testing were introduced for immunotherapy and high-risk anthracycline and anti-HER2 patients, enabling earlier CTR-CVT identification [1]. Additional elements include echocardiographic surveillance per European Society of Cardiology (ESC) guidance [1], rapid-access review, and a digital referral system. Multiprofessional education sessions with national experts were delivered to oncology and cardiology trainees, and a one-stop clinic with same-day electrocardiography (ECG) and echocardiography is in development.

Results / Learning:

Early suspected ICI myocarditis, including asymptomatic cases, was identified — likely missed under a reactive model. Risk stratification improved surveillance adherence. Co-design revealed knowledge gaps prompting multiprofessional education. Key performance indicators (treatment continuity, assessment times, unplanned admissions) are being collected for 12-month analysis.

Sustainability / Next Steps:

The model is designed for regional dissemination and long-term surveillance for young patients exposed to anthracyclines. Referral pathways to structured exercise programmes are also under development.

Take-Home Messages:

An oncologist-led model — unlike traditional cardiology-led services — integrates cardiovascular care into oncology pathways, enabling earlier cardiotoxicity detection and safer cancer treatment. This scalable approach addresses a critical service gap across multiprofessional teams.

References:

1. Lyon AR, López-Fernández T, Couch LS, et al. 2022 ESC Guidelines on cardio-oncology. Eur Heart J. 2022;43(41):4229–4361.

2. Lancellotti P, Suter TM, López-Fernández T, et al. Cardio-oncology services: rationale, organisation, and implementation. Eur Heart J. 2019;40(22):1756–1763.

Submission ID: 29

Title: What happens after Enhance? Multi-professional alumnus outcomes across the North East and Yorkshire

Presented by: Helen Cattermole, enhance Programme Lead; Ruth O'Dowd, Consultant; North East and Yorkshire

Short oral presentations session 1: 09:30 – 10:30 enhance programme development & outcomes

Affiliation to enhance: enhance Programme Lead
Relevant enhance domains: System working; Population health; Person centred practice
Relevant enhance cross-cutting themes: Wellbeing; Leadership

Helen Cattermole (1), John McCullough (2), Ruth O'Dowd (3), David Turner (4), David White (5)

(1) Head of Generalist School Yorkshire & Humber, NHS England; (2) Tutor, North Cumbria School of Generalism, NHS England; (3) Head of North Cumbria School of Generalism, NHS England; (4) Quality Programme Manager, NHSE North East and Yorkshire; (5) Quality Intelligence Manager, NHSE North East and Yorkshire

Introduction

The Enhance programme (1) has been delivered across the North East and Yorkshire (NEY) region since 2021, with a focus on multi-professional participants across health, care and the third sector, who may be senior in their careers, as well as delivering to resident doctors.

One of our initial objectives was to increase retention and improve career progression in hard-to-recruit areas. Having delivered this programme to multiple cohorts, we wanted to examine the effect of participation on retention, career development, and on care quality in practice.

Methods

A questionnaire was emailed to all programme alumni from North Cumbria (NE) and Yorkshire and the Humber (YH) in December 2025, and two further reminders were sent in January 2026.

We asked about the impact of the programme on patient care and service quality, about networks formed and maintained, and about the effect of the programme on their career development and retention within the region. In addition to the quantitative data obtained, free text boxes allowed alumni to provide comments and feedback about the programme.

Results

Questionnaires were sent to 86 alumni from NE and 121 alumni from YH, with responses from 27 participants on each programme (54 total). Responses were spread across all cohorts.

Feedback was positive across all cohorts and both programmes, both on their clinical practice and on their understanding of quality improvement. They had established and maintained relationships beyond their cohorts, and 87% had undertaken new responsibilities, further study or new roles. As a result, 78% felt that they were more likely to remain in the region.

Discussion/Conclusion

This is the first longer-term study of what happens to multi-professional participants after undertaking Enhance. The programme has a positive outcome for patient care and service quality, on participant career development and on retention in under-resourced areas.

This data should be used in conjunction with other evaluations (academic, economic) to demonstrate the continued positive impact of Enhance and is a strong argument for continued funding and programme development.

References

1. https://www.hee.nhs.uk/our-work/enhancing-generalist-skills

Submission ID: 35

Title: Promoting patient-centred Parkinson's Disease practice – upskilling knowledge and confidence on an inpatient ward

Presented by: Jemi Maliyil, Foundation Year 1 Doctor, South West

Poster presentation section 3: 14:05 - 15:15 learning, leadership & inclusion pathways

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; Complex multimorbidity
Relevant enhance cross-cutting themes: Wellbeing

Introduction:

1 in 37 adults in the UK is diagnosed with Parkinson's Disease (PD). Its fluctuating nature and specific symptom management requires a person-centred multi-disciplinary approach to care.

Methods:

On a care-of-the-elderly ward at Bristol Royal Infirmary, 3 cycles of a quality improvement project were conducted to upskill knowledge and confidence of the staff caring for PD patients. In cycle 1, baseline knowledge and confidence were gathered using a data collection survey. 5 teaching sessions were organised addressing topics such as PD medication, palliative care in PD and communication in PD, and the staff re-surveyed. In cycle 2, 3 teaching sessions were run on swallowing, physiotherapy and occupational therapy in PD. Also, an easy-to-read information board on PD was created on the ward. After a month, the staff were re-surveyed. In cycle 3, information was gathered from patients and their carers on what topics they thought important to focus on and 3 further teaching sessions were run on physiotherapy in PD, PD medication and an overview of PD. Over 6 months after the baseline data was collected, a final data collection survey was distributed.

Results:

In knowledge questions, 5 out of 8 had a higher correct answer rate after the teaching sessions. The ones with lower correct answer rates were mainly medication based. In confidence questions, there were higher confidence rankings in 4 out of 5 parameters asked. Medication management was the only parameter with lower confidence rates post teaching programme.

Conclusion:

To continue the teaching programme with a wider range of care providers and having repeats of topics highlighted by PD patients and their carers. There should be a focus on further medication teaching, which has also been widely requested by staff members. Additionally, this teaching should be recorded for staff who cannot attend to view.

Submission ID: 36

Title: Implementing Patient-Initiated Follow-Up (PIFU) in Community Mental Health Teams: A Quality Improvement Project

Presented by: Jovanpreet Rai, Foundation Year 1 Doctor; Muhammad Zeeshan, Foundation Year 3 Doctor; Midlands

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; System working; Complex multimorbidity
Relevant enhance cross-cutting themes: Wellbeing; Leadership

Authors: Muhammad Zeeshan, Mohammed Yousef, Kalol Sain, Jovanpreet Rai, Morouge Elbadawey

Aims:

Traditional Community Mental Health Team (CMHT) follow-up relies on clinician-scheduled appointments at fixed intervals, which frequently fail to reflect individual patient need, contributing to inefficient use of clinical capacity. Patient-Initiated Follow-Up (PIFU) enables patients to request timely review based on symptom change rather than routine scheduling. Despite being a central NHS elective recovery initiative, PIFU has rarely been implemented or evaluated in psychiatric community settings. This project evaluated a PIFU pathway across two CMHTs in Birmingham, with Nechells implementing PIFU and Aston acting as a control using conventional follow-up, assessing impact on access, capacity and patient experience.

Methods:

The pathway was designed using the NHS England PIFU framework and registered with the Trust's Quality Improvement team. A dedicated PIFU category was created within the electronic patient record; clinicians were allocated weekly PIFU review slots and received relevant training. Patients were screened using defined clinical criteria, including diagnostic suitability, health literacy and ability to self-initiate, and consented following thorough explanation. All transfers were discussed at MDT meetings prior to implementation. Patients re-accessed care by contacting the CMHT directly and were offered appointments within

seven days. Uptake and impact on routine appointment availability were monitored and compared between sites. Vacant PIFU slots were repurposed for ad hoc reviews within Clozapine and depot clinics, further optimising capacity.

Results:

Between February and May 2025, 183 patients were placed on the PIFU pathway, with 31 reviews completed. By December 2025, this had grown to 311 patients. In June 2025, Nechells demonstrated a 37.22% reduction in routine clinic waiting times compared to Aston, alongside improved capacity for reviews within 14 days. Patient feedback was strongly positive: 66.7% reported clear understanding of the pathway, 72.7% expressed confidence in accessing care, and 68.2% found access easy. Overall, 76.8% preferred PIFU over traditional follow-up, and 92.6% wished to continue on the pathway.

Conclusion:

Implementing PIFU within CMHTs for selected patients resulted in significant reductions in waiting times, improved clinical capacity and high patient satisfaction. The model supports timely, patient-centred access while optimising resource use. A formal standard operating procedure has been developed and trust-wide rollout across Birmingham and Solihull Mental Health Foundation Trust is planned, with ongoing evaluation.

Supplementary Guidance:

PIFU inclusion criteria consisted of patients:

- Neurotic disorders (mild-moderate depression, anxiety, OCD, ASD/ADHD comorbid)
- Personality disorders +/- substance misuse
- Stable on medications or PRN only; awaiting or completed psychological therapy
- Adequate health literacy, understanding of symptom triggers, and ability to self-initiate appointments.

PIFU exclusion criteria consists of patients:

- Psychosis or bipolar disorder
- Medication changes requiring review (depot, clozapine, lithium/valproate)
- Community treatment orders and/or non-engaging care-coordinated patients
- Complex medical/psychiatric treatment involving multiple professionals.
- Lacking capacity for PIFU (e.g. learning disability, poor initiative).

Submission ID: 38

Title: Time to stop stooling: Improving laxative prescribing in the older adult

Presented by: Oliver Clinton, Foundation Year 1 Doctor, South West

Poster presentation section 2: 09:30 – 10:30 enhance programme – clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working; Complex multimorbidity; Person centred practice
Relevant enhance cross-cutting themes: Transformative reflection; Wellbeing

Describe the problem

Constipation is a common and potentially harmful, particularly for patients on geriatric wards. We found many patients required enemas without adequate prior oral laxative treatment, causing unnecessary patient discomfort and nursing burden. This project aimed to reduce enema use by promoting and monitoring timely, appropriate laxative prescribing before escalation to invasive treatment.

Explain your aims:

Specific: To reduce the proportion of inappropriately prescribed enemas to below 15% in patients on three elderly care wards

Measurable: Percentage of enemas prescribed with sub-optimal prior prescribing (defined as administration without two regular oral laxatives prescribed beforehand)

Achievable: Reviewed as a realistic target with nursing and senior colleagues

Relevant: Significant issue raised by resident doctors

Time: Three months

Describe your baseline measure:

Twenty weeks of retrospective baseline data were collected for all enemas administered on participating wards. We measured the proportion preceded by two regular oral laxatives and displayed this on a run chart to demonstrate baseline variation. This primary process measure will be collected prospectively following each PDSA cycle to assessment improvement.

Describe your use of PDSA cycles (≤60 words)

Following stakeholder feedback, PDSA cycle one delivered ward-based multidisciplinary teaching at departmental teaching, focusing on risk identification and reliable regular

prescribing from different classes. PDSA cycle two will introduce department-wide prescriber and nursing education using real-time data feedback. A third cycle will test a system-level electronic prescribing prompt to improve reliability and sustainability.

What can you conclude from your data?

Baseline data showed that 51.5% of patients receiving an enema had not been prescribed two regular oral laxatives beforehand. Enemas were administered a mean of 9.45 days after admission, and 65% of patients presented with frailty syndromes. Despite regular laxative prescriptions, only 75.3% of doses were administered, with patient refusal the commonest documented reason, highlighting the need for patient education.

What lessons have you learnt?

Regular prescribing alone is insufficient, as administration rates were lower than expected. Future improvement should therefore focus on improving reliability of administration and addressing documented patient refusal through nursing engagement and patient education. Sustainable change will require multidisciplinary co-design, clearer escalation pathways and system-level prompts to support consistent delivery alongside improvements in prescribing practice.

Authors: Oliver Clinton, Rob McFarlane, Molly Crudgington, Alexandre Van Hoof, James Millard

Submission ID: 39

Title: Reducing Sex Inequity in Cardiac Rehabilitation: Implications for Multiprofessional Learning and Service Redesign

Presented by: Priyanth Alaguraja, Core Trainee / ST1-ST3 Doctor, Midlands

Poster presentation section 3: 14:05 - 15:15 enhance programme – learning, leadership and inclusion

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Person centred practice; Population health; Social justice and health equity
Relevant enhance cross-cutting themes: Transformative reflection; Leadership

Background

Cardiac rehabilitation is a key intervention in secondary prevention, improving mortality, morbidity, and quality of life. Despite this, engagement remains low, particularly among women. This reflects wider challenges in person centred care, complex multimorbidity, and health equity. Addressing this gap requires coordinated multiprofessional learning and system level change.

Methods

A systematic review was conducted following PRISMA 2020 guidance, with protocol registration on PROSPERO (CRD420251031126). PubMed was searched for studies published between 2000 and 2025 reporting sex specific data on referral, enrolment, attendance, or completion in cardiac rehabilitation. Forty studies were included, comprising randomised and observational designs. Data were extracted using a standardised framework and synthesised narratively. Risk of bias was assessed using ROB 2 and ROBINS I tools. This work represents a synthesis of published evidence and did not involve identifiable patient data.

Results

Across 40 studies, women consistently demonstrated lower engagement with cardiac rehabilitation. Enrolment ranged from 29 to 52 percent in women compared to 48 to 71 percent in men. Attendance and completion rates were also lower, with women attending fewer sessions and demonstrating higher dropout rates. Barriers were multifactorial. Psychosocial factors included caregiving responsibilities, depression, and reduced social support. Structural barriers included transport limitations, programme inflexibility, and financial constraints, particularly affecting those from lower socioeconomic backgrounds. Referral bias and lack of sex sensitive programme design further contributed to inequity. Emerging evidence suggests that flexible and home based models may improve access and engagement.

Outcomes and impact

This review provides actionable insights for multiprofessional teams. Addressing inequity requires improved referral pathways, clinician education to reduce bias, and redesign of services to better reflect patient needs. Flexible delivery models and targeted support may improve engagement and downstream clinical outcomes. These findings support workforce development aligned to health equity, systems working, and person centred practice.

Conclusion

Sex disparities in cardiac rehabilitation reflect a complex interaction of clinical, psychosocial, and **system level factors. Targeted education, inclusive service design, and multiprofessional collaboration are esse**ntial to improve equity and optimise cardiovascular outcomes.

Authors:

1. Dr Priyanth Alaguraja 2. Mr Ahmed T Elmewafy

References:

1. Suaya JA, Shepard DS, Normand S-LT et al. Use of Cardiac Rehabilitation by Medicare Beneficiaries After Myocardial Infarction or Coronary Bypass Surgery. Circulation 2007;116:1653–62.

2. Firoozabadi MG, Mirzaei M, Grace SL et al. Sex differences in cardiac rehabilitation barriers among non-enrollees in the context of lower gender equality: a cross-sectional study. BMC Cardiovasc Disord 2023;23:329.

3. Armstrong MJ, Martin B-J, Arena R et al. Patients with Diabetes in Cardiac Rehabilitation: Attendance and Exercise Capacity. Med Sci Sports Exerc 2014;46:845–50.

Submission ID: 40

Title: Digital Self Scheduling: A Service Improvement Project for Clinic Optimisation in Outpatient Physiotherapy

Presented by: Tina Fitzsimmons, Allied Health Professional, Physiotherapist, East of England

Short oral presentations session 3: 14:05 - 15:15 innovative ideas and doing things differently: environmental sustainability, system working and digital pathways

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; System working
Relevant enhance cross-cutting themes: Digital; Leadership

Tina Fitzsimmons, Edwards Betts, Dennis McFeely

Physiotherapy Department, Addenbrooke's Hospital, Cambridge

Introduction:

Expanding digital capability and use of technology is one of the core priorities of the NHS long term plan. This will reduce inefficiencies across the system, increase productivity, and support timely access to care. Inefficiencies within the system contributes to poor utilisation of available appointments and increasing Did Not Attend (DNA) rates, with a major impact on Outpatient services.

To support the NHS long term vision on expanding the use of technology and digital capability, Cambridge University Hospitals recently invested in their Electronic Patient Record (EPR) system. This upgrade was to enable patients to self-schedule their appointments and support clinic optimisation across the outpatient setting.

Aim(s):

To improve productivity and utilisation of follow up appointments, reduce DNA rates, improve patient experience, reduce work queue delays within the outpatient Physiotherapy Service.

Methods:

The project team consisted of an EPR analyst (DM), Clinic coordinator (EB) and Clinical Operational Lead (TF). A total of 66 clinic templates assigned to outpatient physiotherapy were reviewed. Clinic codes we re-designed to streamline processes and accurate tracking to the appropriate clinician and service.

Stakeholder engagement with service leads, clinicians, and administrative support staff were undertaken. Regular email communications were sent out to all staff and patients were informed and educated of the impending changes.

All staff were provided with specific training constituting of drop-in sessions over 3 different dates with administrative staff receiving 1:1 training the week before live implementation. Additional support in the form of a hotline was provided for the first 2 weeks of implementation to address and iron out any teething problems.

Results:

122 new clinic templates were designed and implemented. Between October 2025 and February 2026, 2,500 patients out of 3934 patients used the self-scheduling function to book their own follow up appointment. This accounts for 63% of the total outpatient activity during this time. Utilisation of available appointments improved from 78.9% to 85.4%, the second-highest rate recorded in the previous 12 months, a 6.5% increase compared with February 2025. Furthermore, DNA rates within the self-scheduling group were 5% in comparison to 9.6% in those who booked through traditional routes.

Additionally, all onward referrals that historically remained in the work queue are efficiently forwarded to the appropriate services within 48 hours of triage, ensuring timely access to care and no further work queue delays.

Limitations:

Currently, self-scheduling is limited to only follow up appts, which may partly explain the 85% utilisation of appointment figures. However, the system has been future proofed and built to allow the integration of new patient (NP) bookings once enabled. There will be a small proportion of patients who will continue to use traditional methods of booking (e.g. telephone) due to limited access to technology.

Conclusion:

The introduction of self-scheduling follow up appointments in physiotherapy, has empowered patients to take responsibility for their own care, increased clinical productivity, reduced

wasted appointments, and ensured there are no further work queue delays for onward referrals.

The initiative has been recognised by the Trust as a leading example of successful implementation, contributing to increased productivity and overall efficiency.

Submission ID: 45

Title: Optimising emergency department flow through early senior clinical decision-making: a quality improvement evaluation of the See and Sort Stream Initiative (SaSSI) at Royal Preston Hospital

Presented by: Madeleine Truscott, Foundation Year 1 Doctor, North West

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: Population health; System working; Person centred practice
Relevant enhance cross-cutting themes: Leadership

Background

Emergency Departments (ED) across the NHS face sustained pressure, with ongoing challenges in achieving the 4-hour standard. Delays in early clinical assessment and decision-making contribute to overcrowding, prolonged length of stay, and poorer patient experience. Consultant-led models providing early senior input have been shown to improve patient flow. The See and Sort Stream Initiative (SaSSI) was introduced at Royal Preston Hospital as a consultant-led intervention to enhance early assessment and optimise streaming.

Aim

To increase the proportion of ED patients receiving a definitive outcome (discharge or decision to admit) within 4 hours through a senior-led assessment model, improving performance from a baseline of 22% to >40% by June 2026.

Methods

A structured QI approach was used, underpinned by the Lancashire Improvement Method (LIM), which follows four phases: understand, co-design, deliver, and sustain. Baseline data (July–August 2025) informed intervention design. SaSSI operated Monday–Friday (13:00–21:00), prioritising early senior review and rapid streaming. Implementation began in October 2025 using PDSA cycles. Outcome measures included 4-hour performance and time to decision; process measures included time to first assessment. A 14-day reattendance rate and patient feedback were used as balance measures.

Results

Over 160 days, 1,578 patients were assessed. Mean time to first clinical assessment reduced from 219 to 152 minutes (30% reduction), with sustained improvement on SPC analysis. Discharges exceeded admissions on 147/160 days. 4-hour performance improved from 22.1% to 31%, with further gains under optimal conditions. Length of stay decreased, supported by improved streaming to SDEC and SAU. The 14-day reattendance rate remained <2%, supporting safety.

Limitations

The observational design limits causal inference. Outcomes were influenced by staffing and operational pressures, and data were limited to defined operational hours. Longer-term outcomes remain incompletely captured.

Conclusion

SaSSI demonstrates that early senior decision-making can improve ED flow, reduce time to assessment, and maintain safety. LIM provided a structured, scalable framework, supporting development across Enhanced Explore domains and leadership in system-level change.

Impact Statement

Early consultant-led decision-making is a high-impact, scalable intervention that improves flow without compromising safety.

Submission ID: 46

Title: "Stepping outside of our comfort zone": learning through multi-professional shadowing in the NHS

Presented by: John McCullough, GP; Ruth Dowd, Consultant; North East and Yorkshire

Short oral presentations session 1: 09:30 – 10:30 enhance programme development & outcomes

Affiliation to enhance: Current Course Tutor for Enhance North Cumbria School of Generalism and previous Enhance Explore alumni
Relevant enhance domains: System working
Relevant enhance cross-cutting themes: Transformative reflection

Dr John McCullough, Prof. Sam Dearman, Dr Ruth O'Dowd

NHSE Enhance North Cumbria School of Generalism

Background

Excellent patient care depends on effective collaboration across clinical and non-clinical roles within complex systems. Unfortunately, opportunities to understand unfamiliar roles remain limited, contributing to fragmented services and poor horizontal integration between teams.

Aims

To pilot and evaluate a model of structured cross-system shadowing, allowing learners to experience roles outside their usual setting. In the longer-term, to improve system-wide understanding, communication and collaboration to improve patient care across Cumbria.

Context

The North Cumbria School of Generalism delivers the NHSE Enhance curriculum through a 12-month multi-professional programme. We identified an opportunity to provide experiential learning about how different parts of the system operate and interact, anticipating benefits for both learners and host departments.

What you did

We piloted a one-day shadowing programme pairing 20 multi-professional learners across diverse roles (clinical/non-clinical; primary/secondary care). Hosts completed a brief induction and risk assessment. Shadows used a prompt sheet to explore service organisation, team culture, patient safety, digital innovation, sustainability and funding. Learners completed structured reflections and debriefed in Action Learning Sets.

Measures

Post-shadowing evaluation used Likert scales and free-text responses.

Results

The programme was rated educationally valuable (90%), beneficial to host departments (80%) and led to discussions about service improvement (90%). 95% of learners recommended continuing the pilot.

Learners reported having to “step outside our comfort zones” with comments demonstrating transformative reflection across multiple themes. They expressed attitudinal shifts including “a greater appreciation of jobs that are not on the front line” and recognition of “how diverse and emotionally challenging the work can be”, reflecting increased empathy and mutual respect. Learners identified opportunities for change at both personal (e.g. developing leadership style) and system levels (e.g. quality improvement ideas to better integrate maternity and tissue viability services). Constructive feedback to host services highlighted inefficiencies and potential solutions.

Next steps

Shadowing has been embedded within the core curriculum. Future cohorts will be encouraged to apply shadowing insights to inform quality improvement projects.

Key Learning

Structured cross-system shadowing is highly valued by learners. It increases system understanding, supports multi-professional working and develops generalist capability. Further support is needed to translate insights into sustained service improvement.

Submission ID: 49

Title: "Would I start this today?" Reframing Repeat Prescribing as a Real-Time Environmental Intervention

Presented by: Rameshwar Sharma, Advanced Clinical Practitioner (Pharmacist), East of England; Jocelyn Cornish, Senior Lecturer, London

Short oral presentations session 3: 14:05 - 15:15 innovative ideas and doing things differently: environmental sustainability, system working and digital pathways

Affiliation to enhance: Not affiliated
Relevant enhance domains: Environmental sustainability; Complex multimorbidity; Population health
Relevant enhance cross-cutting themes: Transformative reflection

Environmental sustainability is a core NHS value for care. Recognition of the impact of health services on climate change has prompted statutory requirements (Climate Change Act 2008) and commitment towards reduction of the carbon footprint through Net Zero targets (NHSE 2020). Whilst NHS carbon footprint emissions decreased by 14% since the strategy was published (NHSE 2025), there is no room for complacency.

In the last year, NHS organisations, including Integrated Care Boards, have had to publish green plans setting out intentions to support more sustainable practice over the next 3 years, including approaches to sharing good practice and supporting staff to embed sustainability in everyday actions. Supporting the policy commitment, sustainable practice is now embedded within most professional standards for healthcare practitioners (GMC, HCPC) and the NHSE (2025) Multi-professional framework for Advanced practice in England. The intentions are

echoed in the Enhance programme supporting workforce training and education in environmental sustainability towards meeting the aims of the NHS Long Term Plan (2019).

Prescribing often focuses on treatment initiation. However, much avoidable environmental impact is driven by medicines continued without review, particularly in routine care settings. This presentation recasts repeat prescribing as an active clinical decision and outlines a pragmatic, scalable framework for integrating opportunistic review of ongoing prescriptions into everyday consultations. A single prompt - “Would I start this today?” - disrupts passive continuation and shifts repeat prescribing into an active clinical checkpoint, enabling clinicians to deliver immediate, incremental optimisation without defaulting to resource-intensive medication reviews. The approach neutralises key constraints - limited time, follow-up challenges and patient concerns - by combining proportionate, risk-based decision-making with brief and efficient communication. By reducing unnecessary prescribing through opportunistic deprescribing, this model reorients everyday patient encounters as a direct lever for delivering continuous, environmental sustainability interventions at the point of care.

This session highlights practical strategies for sustainable prescribing underpinned by attention to the Triple Bottom Line (Mortimer et al. 2018). While improved patient outcomes, reduced workload and optimised resource use are acknowledged co-benefits, the fundamental premise is that the cumulative effect of micro-decisions in routine clinical practice can drive scalable, system-level environmental sustainability.

Submission ID: 51

Title: Breast reconstruction and learning disability: the lack of easy read resources

Presented by: Megan Kershaw, Foundation Year 1 Doctor, Midlands

Short oral presentations session 2: 11:40 – 12:40 social justice, health equity and population health innovations

Affiliation to enhance: Previously took part in an enhance enable programme
Relevant enhance domains: Person centred practice; System working; Social justice and health equity
Relevant enhance cross-cutting themes: Transformative reflection

Background

Breast reconstruction (BR) post-mastectomy aims to restore breast shape. Complex, preference-sensitive decisions are made by the patient, guided by the surgical team. Information given verbally is supplemented by patient guides, as reference tools for decision-making. Patients with a learning disability (LD) face challenges understanding information required to make complex decisions. Easy read (ER) displays information so that it is easier

for people with a LD to understand. ER is crucial not only for patients, to relieve anxiety and support with decision-making, but for clinicians to be confident that information is not only being communicated but understood. Trusts have a responsibility under the Accessible Information Standard to provide ER resources. The lack of ER on BR was highlighted by a patient, when faced with the important decisions regarding reconstruction.

Aim

To identify and evaluate any medical literature on BR in relation to LD and patient information currently available in ER on BR.

Methods

A scoping search of PubMed and then advanced searches of Medline, Embase, Cochrane Library, CINAHL and Web of Science identified literature on BR and LD, with titles and abstracts screened. A search of Easy Health, MenCap Easy Read Library, the NHS website and social media platforms identified ER currently available on BR.

Results

The medical literature search revealed no studies that looked at BR in relation to LD. The search of patient literature revealed no ER information solely dedicated to BR. However, one ER guide on breast cancer surgery, included a section on reconstruction.

Conclusions

The challenges with communication and complexity in decision-making means the need for informative written communication is greater for patients with a LD. The lack of literature leaves scope for extensive research on BR in relation to LD, and with reference to this study, how communication challenges impact breast cancer care. It would be beneficial nationally to patients and clinicians, for there to be an ER guide dedicated solely to BR. Furthermore, the importance of utilising ER information and filling gaps where resources are lacking should not be overlooked.

Authors - M. Kershaw, R Parks, A.R. Carmichael

Submission ID: 52

Title: Applying Enhance principles to real life: the development of applied Enhance modules

Presented by: Helen Cattermole, Consultant, North East and Yorkshire

Short oral presentations session 1: 09:30 – 10:30 enhance programme development & outcomes

Affiliation to enhance: Enhance Programme Lead
Relevant enhance domains: System working; Person centred practice; Population health
Relevant enhance cross-cutting themes: Leadership: Digital

Helen Cattermole (1), Mohamed Malik (2), Julie Thomson (3)

(1) Head of Generalist School Yorkshire & Humber, NHS England; (2) TPD Generalist School Yorkshire & Humber, NHS England; (3) Programme Support Manager, Generalist School Yorkshire & Humber, NHS England

Introduction

The Enhance programme (1) consists of six core domains and four cross-cutting themes. Most regions, including ours in Yorkshire & the Humber, deliver the core domains as individual modules with cross-cutting themes woven into each module

However, we also deliver a seventh, applied module as part of our multi-professional Enhance Explore. This module takes the core concepts and cross-cutting themes and applies them to clinical or system problems, allowing participants to develop an outward-looking diverse perspective on their learning.

Additionally, we run alumnus continuing professional development (CPD) sessions for Explore 'graduates' which develop the domains and cross-cutting themes further, revising the core Enhance principles and applying this learning to opportunities for deeper exploration.

We present our work hopefully to inspire colleagues to consider this approach, either as part of their core programme or as alumnus sessions.

Approach

Our programme is currently delivering its simultaneous eighth and ninth multi-professional Explore cohorts. We also have an active alumnus network and deliver at least annual face-to-face CPD days to mixed cohorts.

The applied modules, delivered as part of Explore, have covered the following topics:

- Oral health: discussing oral health through various lenses, including inequality, person-centred practice, system working
- Independence in Ageing: a practical, AHP-led module looking at person-centred practice for the elderly
- Major Trauma Systems: following the patient journey from injury to rehabilitation, including not only the patient voice but also a multi-agency simulation, psychology, rehabilitation and injury prevention

We are currently developing a Women's Health module for 2026-7.

Our alumnus expert-led study days have included:

- Leadership: influence, power and rank
- Systems thinking: a deep dive
- Digital: AI and the Future of Work

Feedback from all these sessions has been enthusiastically positive, and reflections on the applied modules in particular have been seen in the end-of-course poster submissions.

Discussion

Applying the Enhance domains and themes to specific topics allows participants to integrate their learning across modules, and to consider how their learning might be integrated into practice. This is carried on with alumnus sessions which allow networking between diverse cohorts, expanding knowledge, and the development of a community of practice.

References

1. https://www.hee.nhs.uk/our-work/enhancing-generalist-skills

Submission ID: 53

Title: Evaluation of an AI-Assisted Documentation Tool in the Emergency Department: A Single-Centre Study of Accurx Scribe

Presented by: Mina Abdul, Foundation Year 1 Doctor; Hussein Amman Ahmed, Foundation Year 1 Doctor; Midlands

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; System working
Relevant enhance cross-cutting themes: Digital

1A. U. Ahmed, 1M. A. Hussein, 2O. Shepherd, 3R. Pelasur,

Background

Clinical documentation within Emergency Departments (EDs) represents a significant proportion of administrative workload, often limiting the time available for direct patient care and contributing to reduced departmental efficiency. Within the context of NHS workforce pressures, there is increasing emphasis on digital innovation to support service sustainability,

enhance generalist capabilities, and improve patient flow. The UK Foundation Programme Office Enhance Programme promotes exactly these principles, encouraging foundation doctors to develop skills in quality improvement, digital health, and system-based practice. This study evaluated Accurx Scribe, an AI-assisted clinical documentation tool, introduced during a pilot at Alexandra Hospital, Redditch. The primary aim was to assess whether AI-supported documentation could improve efficiency while maintaining patient interaction quality.

Methods

A prospective time-and-motion study was conducted over two consecutive days using a split-shift design. Twelve clinicians completed 8–9 hour shifts divided into control (standard documentation) and intervention (Accurx Scribe) phases. Real-time observational data were recorded using structured capture sheets. Primary outcomes included Time to See Patient (TTP) and Time to Document (TTD). Nine complete datasets were included in the final analysis.

Results

Mean patient interaction time remained stable at 12 minutes across both phases, indicating no adverse effect on clinician–patient engagement. Mean documentation time decreased from 8 minutes in the control phase to 7 minutes with AI support, representing a 12.5% reduction. When extrapolated to an average ED workload of 450 patients per day, this equates to an estimated 7.5 hours of clinical time saved daily, with potential capacity to see approximately 38 additional patients.

Discussion

This study demonstrates that AI-assisted documentation can improve departmental efficiency without compromising patient-facing time, directly aligning with Enhance Programme objectives around innovation, service improvement, and developing foundation doctors as future NHS system leaders. The findings support the Enhance emphasis on digital literacy and evidence-based quality improvement within clinical practice. However, limitations including small sample size, incomplete datasets, variability in clinician engagement, and workflow integration challenges should be acknowledged. Further larger-scale studies are required to validate findings and explore long-term impacts on patient safety, staff workload, and sustainability of implementation within NHS ED settings.

Submission ID: 55

Title: Beyond Borders, Beyond Boundaries: Empowering Allied Health Professionals Internationally to Transform Community Palliative Care

Presented by: Mallika Fonseca, Core Trainee / ST1-ST3 Doctor, East of England

Poster presentation section 3: 14:05 - 15:15 enhance programme – learning, leadership and inclusion

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Digital; Leadership

Background

Palliative care has long been seen as the realm of the doctor. However, as care increasingly shifts from hospital-based to community settings, the effective utilisation of Allied Health Professionals (AHPs) becomes a critical workforce strategy (1). This project highlights the strengths and challenges in upskilling AHP's in hospice and primary care settings in two different countries (UK & India) to enhance community palliative care and reduce the burden on medical teams.

Approach

Data was drawn from surveys and insights made during cross-site visits through an international collaboration between the UK-based Cambridge Global Health Partnerships (CGHP) and the Rama Foundation, which links with healthcare services in Northern India.

Discussion

Indian hospice care is largely cancer-focused with limited awareness and provision for non-cancer palliative needs. National policy and funding determine palliative care in both countries, influencing referral structures and quality of care.

The UK team was struck by the central role families play in care delivery in India, working at grassroots levels in a minimal resource setting – there is a strong perception of fear of being perceived to have 'given up' if they accept palliative care. In addition, formal AHP involvement remains limited, with professionals viewing the field as offering limited career development.

The site visit in February 2026 focused on gathering data to guide the development of a targeted blended training programme to strengthen AHP capacity through a reciprocal visit of allied health professionals from India.

Outcomes/Relevance

The outcome of the project is to gather data to design a structured training programme for AHP's from India. Through the last 8 years, the project has encouraged bilateral learning - integrating India's community-driven model with the UK's multidisciplinary AHP's integration.

References

(1)- Saini, S. (2024). The Imperative for a Paradigm Shift in India's Healthcare Workforce. Annals of Neurosciences, 31(3), 149–151. https://doi.org/10.1177/09727531241271428

Authors:

Mallika Maria Fonseca1, Julie Burkin2, Anna Spathis3 , Taranjit Singh4, Jo Byers5

1- GP registrar; Granta Medical Practices, Cambridge Global health partnerships (CGHP),
2- OT, Cambridge University Hospital (CUH); Supervisor, CGHP
3- Consultant palliative care, CUH; Supervisor, CGHP
4- Medical officer, Ganga Prem Hospice, Uttarakhand, India
5- OT, Arthur Rank Hospice, Cambridge

Submission ID: 56

Title: Improving early fluid resuscitation in Acute Pancreatitis

Presented by: Josh Grant, Foundation Year 2 Doctor; Rachael Cresswell, Foundation Year 2 Doctor; South West

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Digital; Leadership

Acute pancreatitis is a common cause of emergency hospital admission and is associated with significant morbidity, particularly in patients who progress to severe disease requiring intensive care unit (ITU) admission. Early, and appropriate fluid resuscitation is a cornerstone of management, yet both under- and over-resuscitation are linked to worse outcomes. (1) At our institution, variability in fluid prescribing practices and a lack of uniform standards of monitoring presented key gaps in care.

National fluid guidance details a preliminary target of 25/30ml/kg/hr. Given patients are at risk of sequestration, we initially targeted a minimum daily fluid target of 30ml/kg using a mixture of 0.9% Saline and Hartmann's. (2)

Pre-intervention data over a one-month capture demonstrated suboptimal compliance with recommended monitoring parameters and variable fluid management, with a proportion of patients requiring escalation to ITU for organ support. The original cohort of 16 patients ages 29-90 found that 31% of patients did not receive the guideline recommended fluid resuscitation in the first 48hours of their admission, and none had urine output monitored.

This quality improvement (QI) project aimed to optimise fluid resuscitation in patients admitted with acute pancreatitis through the implementation of a standardized order set emphasising early fluid administration, and stringent urine output monitoring.

Following implementation, we observed improved documentation of urine output, more consistent clinical reassessment, and greater adherence to fluid prescribing guidelines.

Preliminary outcomes suggest a decrease in the rate of escalation to ITU, alongside improved overall patient management and staff confidence in treating acute pancreatitis. This project highlights the importance of structured, protocol-driven care and continuous monitoring in the early phase of acute pancreatitis. Sustained efforts and further data collection will be essential to confirm long-term impact and ensure scalability across other acute care settings.

*the post intervention data is being collected at the time of writing - but has not been completed and as such cannot be published in this abstract.

1. https://bestpractice.bmj.com/topics/en-gb/66/treatment-algorithm

2. https://www.nice.org.uk/guidance/cg174/resources/intravenous-fluid-therapy-in-adults-in-hospital-algorithm-poster-set-191627821

Submission ID: 59

Title: AI Chatbot vs Policy Hub for Accessing Clinical Guidelines: A Proof-of-Concept Quality Improvement Study

Presented by: Nusrat Islam, Foundation Year 1 Doctor; Isabelle Shepard, Foundation Year 1 Doctor; North West

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working
Relevant enhance cross-cutting themes: Digital

Accessing local clinical guidelines is fundamental to safe prescribing and effective clinical decision-making. However, systems such as Policy Hub can be time-consuming and challenging to navigate, particularly for rotational staff unfamiliar with local processes. This can lead to delays, missed interventions, and variation in guideline implementation. AI chatbots offer a novel approach by enabling rapid, natural language access to guideline-based information.

This study aimed to evaluate the feasibility, efficiency, accuracy, and user experience of an AI chatbot for accessing Trust guideline-based information compared to the Northern Care Alliance Policy Hub.

A proof-of-concept comparative evaluation was conducted using five clinically relevant scenarios derived from local Trust guidelines, including electrolyte management, peri-operative medication, antimicrobial prescribing, and hyperosmolar hyperglycaemic state (HHS). Participants (FY1 doctors and SHOs) completed scenarios individually using either an AI chatbot or Policy Hub. Time to answer was recorded, and accuracy was assessed using predefined mark schemes. User experience was evaluated via a post-session survey. No real patient data were used.

Preliminary findings suggest that the AI chatbot enabled more consistent and efficient access to guideline-based information, particularly in scenarios requiring interpretation or where guidance was not explicitly indexed. Policy Hub performance was more variable and dependent on navigation and familiarity. Accuracy was comparable between both methods. Limitations included occasional system latency and the need for prompt refinement to obtain complete responses.

AI chatbots show promise as a tool to improve the accessibility and usability of clinical guidelines, particularly in complex or poorly indexed scenarios. However, their effectiveness is influenced by user interaction and system performance, and there remains a need for verification to ensure safe practice. Further work is required to evaluate scalability, reduce hallucinations, and support cost-effective and sustainable implementation.

Submission ID: 61

Title: Building MDT confidence in recognising deterioration in dementia patients: a ward-based audit and educational quality improvement project

Presented by: Girishkumar Sivakumar, Foundation Year 1 Doctor, London

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Previously took part in an enhance explore programme
Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Digital; Wellbeing

Building MDT confidence in recognising deterioration in dementia patients: a ward-based audit and educational quality improvement project

Background

Inpatient dementia patients represent one of the most clinically complex multi-morbid populations in the NHS. Acute deterioration frequently presents atypically — through subtle behavioural, mood, or functional change rather than classic physiological signs — yet MDT staff rarely receive structured training in recognising these patterns. Gaps in confidence directly risk delayed escalation, preventable harm, and reduced quality of life. This project addressed a workforce learning gap on an older adult inpatient psychiatric ward (Silver Birches) serving a diverse North London population.

Aim

To establish baseline MDT confidence in recognising, documenting, and escalating acute and subtle deterioration in dementia patients, and to co-design a targeted educational intervention based on identified gaps.

Context

Thirteen MDT respondents including registered nurses, healthcare assistants, and allied health professionals on a 21-bed inpatient dementia ward. Anonymous survey conducted November 2025. Rio (EPR) and EPMA form the digital documentation infrastructure.

What we did

An 11-item anonymous Likert confidence survey (scale 1–5) with three free-text questions was distributed to all ward-based MDT staff. Items covered acute recognition, subtle change detection, ABCDE adapted for non-verbal patients, electrolyte interpretation, escalation decision-making, Rio and EPMA utilisation, and MDT communication. Thematic analysis was applied to free-text responses.

Results

Overall mean confidence: 3.64/5. Strengths in subtle change identification (4.54/5) and MDT communication (4.23/5). Critical gap: electrolyte interpretation (2.92/5; 46% scoring 1–2). Moderate gaps in ABCDE adapted for dementia (3.23/5) and EPMA utilisation (3.54/5). Four qualitative themes: patient communication barriers, demand for scenario-based training, inadequate baseline-knowledge documentation across shifts, and delayed doctor response to nursing escalations — a systemic finding escalated to ward governance independently.

Next steps

A five-session MDT teaching and simulation programme covers electrolytes in dementia, adapted ABCDE, escalation pathways, EPMA monitoring, and Rio documentation. Cycle 2 re-audit closes the loop by end of training year, targeting overall mean ≥4.0/5.

Take-home messages

MDT confidence audits are a low-resource tool for identifying workforce learning gaps in complex multi-morbid populations. Qualitative data surfaces systemic barriers that scores alone cannot capture. Educational interventions must be paired with structural pathway recommendations for sustainable change.

Submission ID: 63

Title: Crisis Connect Network: A Digital Platform Approach to Health Equity in East Yorkshire

Presented by: Kathryn Duck, VCSE Sector; Adam Taylor, VCSE Sector; North East and Yorkshire

Short oral presentations session 2: 11:40 – 12:40 social justice, health equity and population health innovations

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: Population health; Social justice and health equity; System working
Relevant enhance cross-cutting themes: Digital

Abstract

Crisis Connect Network demonstrates how digital inclusion, delivered through VCSE organisations, can reduce inequalities in access to NHS services among underserved populations in East Riding of Yorkshire, with potential to scale nationally. It also supports workforce learning by enabling multiprofessional teams to develop shared understanding of social determinants of health through real-time, community-generated data, strengthening collaboration across health, social care, and voluntary sectors.

Background / Problem

Digital exclusion disproportionately affects older adults, people in poverty, and rural communities—groups with high multimorbidity and reliance on NHS services. In East Riding of Yorkshire, VCSE organisations delivering digital inclusion, food support, and crisis intervention worked in silos, with no shared data infrastructure and high reporting burden. As a result, unmet need remained hidden and people in crisis fell between services.

Aim

To implement a shared platform enabling VCSE organisations to coordinate support, share data, and generate population insight, using digital inclusion to improve NHS access while supporting workforce learning.

Context

The model operates across East Riding of Yorkshire in two organisations (with a third in development), supporting digitally excluded adults, food-insecure households, and those facing multiple crises. Delivery involves VCSE, health, and local government partners.

What we did

We co-produced a modular web platform supporting service delivery, referrals, and anonymised data sharing without additional reporting burden. Digital sessions focus on bridging the digital divide, building individuals confidence in using technology, including using the NHS App.

Measures / Evaluation

Fourteen months of data include demographics, digital outcomes, referrals, and service use. Qualitative feedback is captured via SMS and staff input.

Results / Learning

Findings show improved coordination, reduced duplication, and greater visibility of unmet need not captured in NHS datasets. Digital inclusion offers a scalable route to improving access, while shared data supports population insight and workforce learning.

Ethics / Governance

Conducted as a service evaluation using anonymised data in line with information governance standards.

Next steps & Key messages

Expansion is underway with partners. VCSE data can inform population health and commissioning; digital inclusion improves access; shared platforms enable collaboration, learning, and health equity.

Submission ID: 65

Title: Endorsing Results in Digital Health Records – are we Certain?

Presented by: Joanna Hood, Foundation Year 2 Doctor; Manika Kaur Ghattarody, Foundation Year 2 Doctor; East of England

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: System working
Relevant enhance cross-cutting themes: Digital

Introduction/Background

Within AlexHealth (Cerner), Princess Alexandra Hospital NHS Trust policy requires that investigation results are digitally endorsed by the appropriate clinician. A focused review of critical radiology reports demonstrated that results were more frequently acknowledged in clinical notes than formally endorsed within the electronic health record. This qualitative study aimed to identify and explore human factors contributing to this discrepancy.

Methods

A six question questionnaire was distributed to all resident doctors at Princess Alexandra Hospital. The survey explored clinicians' awareness of digital result endorsement and their perceptions of the endorsement policy. Responses will be analysed using Grounded Theory, with emergent themes mapped to the PEAR human factors framework: Person, Environment, Actions, and Resources.

Results

To date, 57 doctors have responded, and data collection remains ongoing. Preliminary analysis identified key themes relating to limited awareness of endorsement requirements, high clinical workload, and the volume of results requiring endorsement per patient.

Discussion/Conclusion

Preliminary findings suggest that mechanisms for endorsing results within Cerner are poorly aligned with clinical workflows, and awareness of digital endorsing processes is inconsistent. Streamlining and standardising endorsement processes within Cerner, alongside targeted training, may improve compliance with trust policy and enhance patient safety.

Submission ID: 66

Title: OT Draw: Clinician-Led Digital Innovation to Improve Housing Adaptations, Workforce Capacity and Patient Experience

Presented by: Ajith Philip, Physiotherapist; Adam Lambert, OT Lead; East of England

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Person centred practice; System working
Relevant enhance cross-cutting themes: Leadership; Digital

Background

Occupational Therapists (OTs) and Assistant Practitioners in Community Rehabilitation Services assess patients for major and minor housing adaptations to promote safety, independence and wellbeing. Historically, this relied on hand-drawn plans, scanned diagrams and narrative descriptions, leading to variable quality, transcription errors, repeated contractor queries and delays. This increased clinician administrative burden and negatively affected patient flow.

Aim

To implement and evaluate a digital drawing solution to improve the accuracy, efficiency and consistency of housing adaptation plans, enhance staff experience, and support timely, person-centred patient outcomes.

Context

This clinician-led service improvement was delivered across a county-wide community rehabilitation service operating under a Section 75 agreement with Adult Social Care, in partnership with Housing Associations, Home Improvement Agencies and contractors. The project aligns with Enhance domains of Person-centred Practice and Systems Working, and the cross-cutting themes of Digital Transformation and Leadership.

What we did

A structured improvement and digital procurement approach was undertaken, beginning with problem definition, stakeholder engagement and baseline process mapping. A time-and-motion study was completed to identify variation, inefficiency and risk within existing workflows.

A comprehensive market scan identified a wide range of digital solutions, which were shortlisted against agreed clinical and technical criteria. Clinicians from across multiple neighbourhood teams participated in structured workshops, trialling shortlisted options using real clinical measurements and scenarios. Timed task completion, structured questionnaires and qualitative feedback were collected, with measures taken to reduce confirmation bias through standardised scenarios and rotation of software order.

OT Draw was selected based on clinical usability, functional capability, compliance with occupational therapy standards and integration into community workflows. Information Governance approvals were secured, a detailed business case was developed demonstrating quality, workforce and system benefits, and equitable access arrangements put in place. Training, implementation planning and benefits realisation were embedded from the outset, with added touchscreen devices trialled to support real-time use during home visits.

Evaluation and Results

Baseline assessment indicated that hand-drawn plans required a substantial proportion of clinician time. Timed testing demonstrated time savings of approximately 70–90% depending on adaptation type, with particularly high reductions for stair and ramp diagrams. Staff reported reduced administrative burden, improved accuracy, fewer follow-on queries from partners and increased confidence when sharing plans with patients. Capacity modelling suggests a significant uplift in service throughput without increasing workforce.

Learning and Next Steps

This project demonstrates how clinician-led digital transformation can deliver sustainable efficiency, strengthen system working and improve patient experience. Benefits monitoring continues as the solution transitions into business as usual, with learning transferable across community and integrated care services.

Submission ID: 67

Title: Reducing CT imaging of low-risk transient ischaemic attack patients in an emergency setting: quality improvement project with introduction of guideline

Presented by: Laura Burrows, Foundation Year 1 Doctor; Lauren Dinsdale-Young, Foundation Year 1 Doctor; Midlands

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; Environmental sustainability
Relevant enhance cross-cutting themes: Leadership

Authors: L Burrows, L Dinsdale-Young, A Jacklin

Rationale for audit

NICE guidance does not specify what symptoms in transient ischaemic attack (TIA) patients require imaging (1). Clinicians must rely on personal judgement/preference causing excess computed tomography (CT) scans, increasing patient length of stay (2) and not prioritising patient-centred care.

Method

We carried out a retrospective audit of patients who had visited Kings Mill hospital (KMH) Emergency Department (ED) between the dates of 1/1/2025 and 28/10/2025, who had a CT head and a coded diagnosis of TIA on their ED discharge summary.

Findings: SystmOne identified 424 people with TIAs, 304 of whom had a CT. We looked at a random selection of these 304 and found that 30/129 (23.3%) patients had a CT head despite resolved symptoms and no red flags. Extrapolated, imaging could be reduced by 77 TIA patients a year at KMH alone.

Going forwards

We locally implemented guideline and decision aid with clear red flags for when to scan, to improve: patient exposure to radiation, ED wait times, pressure on CT scanners, staff time such as porters and radiologists (3), decision fatigue of ED clinicians and overall physical and environmental cost reduction.

A second cycle is pending. This guideline may be of value to other hospitals, creating a mass effect to nationally reduce unnecessary imaging.

References

1. Stroke and transient ischaemic attack in over 16s: diagnosis and initial management (2019) NICE guideline NG128 [Available from: https://www.nice.org.uk/guidance/ng128/chapter/Recommendations#imaging-for-people-who-have-had-a-suspected-tia-or-acute-non-disabling-stroke].

2. Kanzaria HK, Probst MA, Ponce NA, Hsia RY. The association between advanced diagnostic imaging and ED length of stay. Am J Emerg Med. 2014;32(10):1253-8.

3. Anzai Y, Heilbrun ME, Haas D, Boi L, Moshre K, Minoshima S, et al. Dissecting Costs of CT Study: Application of TDABC (Time-driven Activity-based Costing) in a Tertiary Academic Center. Acad Radiol. 2017;24(2):200-8.

Submission ID: 68

Title: Improving multi-professional understanding of complex multimorbidity: 'Making it real'

Presented by: John McCullough, GP; Ruth O'Dowd, Consultant; North East and Yorkshire

Poster presentation section 3: 14:05 - 15:15 enhance programme – learning, leadership and inclusion

Affiliation to enhance: Course Tutor, NHSE Enhance North Cumbria School of Generalism
Relevant enhance domains: Complex multimorbidity
Relevant enhance cross-cutting themes: Transformative reflection

John McCullough, Sam Dearman, Ruth O'Dowd

Background

Compared with the UK average, Cumbria has an older population and a higher prevalence of disability and is therefore likely to experience greater levels of multimorbidity. Managing multimorbidity safely and effectively presents challenges for both clinical and non-clinical teams requiring coordinated, cross-organisational working. Despite this, there has been no dedicated educational provision on multimorbidity for healthcare staff in our region.

Aim

Our short-term aim was delivery of high-quality teaching on multimorbidity to a multi-professional audience. This aligns with a broader strategic ambition to develop a network of professionals capable of delivering cross-organisational quality improvement to better meet the needs of people living with multimorbidity in our region.

Context

The North Cumbria School of Generalism delivers the NHSE Enhance curriculum through a 12-month multi-professional education programme. A formal review of the healthcare risk landscape in our region identified a gap in teaching on multimorbidity, which prompted development of a new dedicated module.

What you did

Using existing Enhance resources, we developed a module on complex multimorbidity with input from a service-user with lived experience, programme alumni and representatives from primary and secondary care. The module was piloted in 2025, then refined for a larger cohort in 2026.

Measures

After completion, learners completed a feedback survey (Likert-scale and free text; n=39, 100% response rate).

Results

Learners reported increased confidence (95%) and improved knowledge and skills (97%) in managing multimorbidity. Qualitative feedback demonstrated transformative reflection, particularly following the service user contribution. Participants described the session as ‘eye opening’ and ‘making it very real’, with many noting a shift in understanding of patient experience. One learner reflected that it ‘gave me much more thought to the challenges patients face’, while another noted the experience would stay with them throughout their career.

Next steps

This module is now embedded within our core programme. We have updated assessment criteria to increase focus on quality improvement and application of learning.

Key Learning

Dedicated generalist teaching on multimorbidity is highly valued. Development and delivery with a service user were central to success, facilitating transformative reflection. Further work is needed to translate learning into measurable service improvement.

Submission ID: 70

Title: Review of annual diabetic reviews for Type 2 diabetics under the age of 40 years old in the Orchard practice as of April 2026.

Presented by: Helen Winterburn, Foundation Year 2 Doctor, North West

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: System working; Population health
Relevant enhance cross-cutting themes: Leadership; Digital

Review of annual diabetic reviews for Type 2 diabetics under the age of 40 years old in the Orchard practice as of April 2026 by Dr Helen Winterburn and Dr Charlotte Cooke

Introduction

Type 2 diabetes (T2DM) is increasing in younger populations causing concern for the future burden of disease (1). Young people with T2DM are presenting with higher BMI, dyslipidaemia and high urine ACR increasing the complication risks (2). Reviews have shown glycaemic control alone in early stages is not sufficient to prevent cardiovascular risks leading to morbidity and mortality earlier (2). For this reason, NICE in 2026 recommended all young T2DM should be started on metformin, SGLT2 inhibitor and either a GLP-1 receptor antagonist or Tirzepatide.

Methods

13 patients met our criteria of T2DM and under 40 years. Using EMIS I collected information on the 8 annual diabetic review sections as per Diabetes UK guidelines. These categories were HbA1c, cholesterol, renal profile, urine ACR, foot checks, BMI, blood pressure, eye screening and medication reviews.

Results

13 patients with 54% female and 46% male. 84.6% had a HbA1c with 69.2% being <48. 46.2% had a urinary ACR with 90.9% being normal and 10% being raised. 76.9% had their BMI calculated, 7.7% were overweight and 92.3% were obese. 15.4% were on triple therapy, 30.8% on dual therapy, 30.8% on single therapy and 23.1% had no medications.

Discussion

Patients were requiring multiple reviews to complete all components some had at least 3. Appointments had missing investigations, meaning another appointment had to be made. To resolve this a new system has been proposed; 3 weeks before their annual review they will be notified to collect a urine pot labelled ACR. Then 2 weeks before they will have a bloods appointment and return their urine sample. If the patient fails to pick up a urine pot, return a urine pot or attend for bloods the review appointment will not go ahead and converted into on-the-day appointments, and their review will be rescheduled. Without these requirements being fulfilled a decision around medication cannot be made. The section with least compliance was the urinary ACR with 46.2%. To increase this compliance, pots will be labelled ACR, so reception staff and patients know it is important for checking kidney health as this has wider implications for blood pressure and cardiovascular health.

References

(1)- Alberti G, Zimmet P, Shaw J, Bloomgarden Z, Kaufman F, Silink M, Consensus Workshop Group. Type 2 diabetes in the young: the evolving epidemic: the international diabetes federation consensus workshop. Diabetes care. 2004 Jul 1;27(7):1798-811.

(2)- Constantino MI, Molyneaux L, Limacher-Gisler F, Al-Saeed A, Luo C, Wu T, Twigg SM, Yue DK, Wong J. Long-term complications and mortality in young-onset diabetes: type 2

diabetes is more hazardous and lethal than type 1 diabetes. Diabetes care. 2013 Dec 1;36(12):3863-9.

Submission ID: 73

Title: Creating space for reflection: Peer-led implementation of Enhance person-centred practice teaching in foundation training

Presented by: Aditi Mukherjee, Foundation Year 3 level/ST1 level - Clinical Teaching Fellow Role, London

Short oral presentations session 1: 09:30 – 10:30 enhance programme development & outcomes

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; System working; Social justice and health equity
Relevant enhance cross-cutting themes: Leadership; Transformative reflection

Background/Problem

Early postgraduate training often prioritises clinical and service demands over structured development in reflective practice, person-centred care, and systems awareness. The Enhance programme promotes the development of socially responsible, reflective, and systems-aware clinicians, although exposure within Foundation Year 1 (FY1) training may be limited. A local gap was identified in values-based educational opportunities for FY1 doctors aligned with compassionate, inclusive, and sustainable healthcare practice.

Aim

To implement and evaluate a peer-led educational initiative embedding the Enhance Person-Centred Practice module within mandatory FY1 teaching.

Context and Intervention

Following attendance at an Enhance learning event and independent completion of the programme, a peer-led teaching initiative was developed collaboratively with the Foundation team and educational supervisors. The Person-Centred Practice module was integrated into protected FY1 teaching sessions due to its relevance to empathy, holistic care, communication, and reflective practice. Sessions used interactive approaches including case-based discussion and facilitated group reflection to encourage engagement with topics beyond clinical protocols. Following strong trainee engagement, additional optional evening sessions exploring wider Enhance themes were introduced alongside tailored reflective learning

resources. The initiative aligned with DEMEC's vision of supporting a compassionate and sustainable healthcare workforce.

Evaluation

Impact was evaluated using anonymised post-session surveys collecting quantitative and qualitative feedback regarding engagement, facilitation, relevance, and perceived educational value.

Results/Learning

Twenty-six FY1 doctors completed evaluation forms. Seventy-seven percent rated the session delivery 5/5, while 81% agreed that the session met its objectives. All participants reported that discussion and participation were actively encouraged, and 88% rated facilitation as highly engaging. Qualitative feedback highlighted appreciation for the practical relevance of the content, opportunities for reflective discussion, and strong interest in further Enhance sessions. Participants particularly valued dedicated space to explore identity, ethics, empathy, and patient-centred values within postgraduate training. The initiative demonstrated strong engagement, acceptability, and feasibility within an existing teaching programme.

Conclusions and Next Steps

Peer-led implementation of Enhance teaching may provide a practical and scalable approach to embedding reflective, person-centred education within postgraduate training. Creating structured opportunities for discussion of empathy, communication, and holistic care may support the development of thoughtful, ethically grounded, and systems-aware clinicians, with potential benefits for multidisciplinary collaboration and person-centred patient care.

Submission ID: 74

Title: Improving ReSPECT Plan Quality in Palliative Inpatient Care

Presented by: Teni Odukomaiya, Foundation Year 2 Doctor, Midlands

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Currently in an enhance enable programme
Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Digital; Transformative reflection

Introduction

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) documentation is vital, as it informs clinicians about a patient's health status, priorities and appropriate treatments. It supports personalised emergency care based on individual priorities. As ReSPECT is used nationally, consistent and accurate completion is essential for safe, person-centred decision making and for enabling clinicians to act confidently during time-critical situations(1). Digitalising forms is crucial for improving accessibility and standardisation across the healthcare community(2).

Aim

To assess compliance with national ReSPECT standards within the Nightingale Macmillan Unit (NMU) at the Royal Derby Hospital.

Standard

The trust policy based off the ReSPECT national guidelines, with an expected standard of 100%.

Methods

A retrospective audit reviewing all inpatients in the NMU during November 2025 (18 patients) and January 2026 (22 patients). Data included form type (paper/electronic), documentation of patient priorities and clinical recommendations. On 3rd December 2025, induction for resident doctors in the cancer business unit included brief guidance on completing forms appropriately. Outcomes from both cycles were compared to evaluate changes following the intervention.

Results

Completion of digital forms was similar across cycles (66.7% vs 68.2%). Placement in the purple-bordered pocket decreased from 100% to 86.7%. Clinical information remained consistently documented (100%). Use of the prioritisation scale decreased (61.1% to 53.9%). Documentation of patient values decreased (77.8% to 63.6%), while fears increased (44.4% to 50%). Realistic interventions and DNACPR decisions were recorded in all cases. Senior clinician signatures improved from 61.1% to 81.8%.

Conclusion

Compliance with core ReSPECT standards stayed high in both cycles, especially for clinical summaries, DNACPR decisions and intervention planning. Digital completion and person-centred elements, such as priorities, values and fears, remained suboptimal. Senior clinician signatures improved after the induction session. Overall, structural elements were reliable, but reflective, person-centred documentation requires improvement.

Recommendations

Arrange formal teaching with greater emphasis on documenting patients' values, fears and use of the prioritisation scale. Maintain improved senior clinician signatures by ensuring resident doctors record the on-call consultant after discussion. Continue monthly audit cycles, including the trust wide ReSPECT plan audit, to reinforce and sustain improvements in ReSPECT plan quality.

References

[1] Fritz Z, Slowther AM, Perkins GD. Resuscitation policy should focus on the patient, not the decision. Bmj. 2017 Feb 28;356.

[2] Fielden L, Lynch D, O'Hare P, Campbell S, Petrie K. Quantitative and qualitative evaluation of the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process in Forth Valley 2019 [Internet]. NHS Forth Valley; 2019.

Submission ID: 76

Title: Improving Advanced Care Planning Through Standardised Documentation and Staff Education: A Quality Improvement Project

Presented by: Amy Swords, Foundation Year 2 Doctor, North West

Short oral presentations session 3: 14:05 - 15:15 innovative ideas and doing things differently: environmental sustainability, system working and digital pathways

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: Person centred practice; System working; Complex multimorbidity
Relevant enhance cross-cutting themes: Transformative reflection

Background

Advanced care planning (ACP) enables patients to express their preferences for future care, including treatment decisions and preferred place of care or death. Despite its importance in delivering person-centred care, ACP discussions and documentation are often inconsistent. At a district general hospital, a lack of standardised tools and limited staff confidence were identified as key barriers, with baseline data showing low rates of ACP completion.

Methods

A Quality Improvement Project was undertaken to improve ACP discussions and documentation. A standardised ACP form was developed and piloted on a medical ward.

Following initial feedback, the form was refined and supported by targeted staff training on conducting ACP discussions and completing documentation. Training was incorporated into induction programmes, including for international medical graduates. Weekly audits were conducted to assess ACP completion rates and documentation quality.

Results

Between November 2024 and February 2025, 207 ACP forms were analysed. Following implementation of the intervention, ACP discussion and documentation rates increased from 3% to 71%. Staff feedback indicated improved confidence in initiating conversations and greater clarity in documenting patient preferences. Iterative changes to the form and ongoing education contributed to sustained improvement.

Discussion

This project demonstrates that combining structured documentation with targeted education can significantly enhance ACP uptake. By addressing both system and behavioural barriers, the intervention promotes consistent, patient-centred communication and shared decision-making. Embedding training within induction supports sustainability and ensures accessibility for a diverse workforce.

Conclusion

A standardised ACP tool, supported by staff education, significantly improved ACP discussion and documentation. This scalable intervention has potential for wider implementation across clinical settings, supporting the delivery of person-centred care and improving alignment between patient wishes and clinical decision-making.

Submission ID: 77

Title: Structured “Speak-Up” sessions: Promoting wellbeing and psychological safety for Obstetrics and Gynaecology (O&G) Residents

Presented by: Shailja Verma, Higher Trainee Doctor; Asmita Patwardhan, Consultant; Midlands

Poster presentation section 3: 14:05 - 15:15 enhance programme – learning, leadership and inclusion

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: System working; Social justice and health equity
Relevant enhance cross-cutting themes: Wellbeing

Authors - Shailja Verma, Miss Asmita Patwardhan & Miss Elizabeth Swift (Affiliation - University Hospitals of Leicester NHS Trust)

Problem

Doctors in O&G often experience psychological danger at work. This affects wellbeing, fuels perceptions of discrimination & undermining behaviour, and erodes trust in supervisory structures. Traditional escalation routes can feel formal, hierarchical, and inaccessible.

Aim

To establish a psychologically safe, trainee-led “Speak-Up” forum that enables O&G doctors to raise concerns early, access timely support, and improve departmental culture, and training.

Context

The initiative was introduced in a busy O&G department, serving wards, assessment areas and emergency settings. Core team comprised an inclusive resident doctors' team and college tutors. Primary users were resident doctors (trainees, SAS/LEDs, IMGs).

What you did

A regular, informal “Speak-Up” session was created where any trainee could drop in to discuss concerns. Ground rules emphasised respect, confidentiality, and prompt acknowledgement. Individual cases (e.g. undermining behaviour, difficulty accessing supervision, training time being eroded, distressing clinical encounters) were explored, with follow-up actions agreed and escalated via college tutors. There was continuous informal promotion via trainee networks and group chats.

Measures

User-reported outcomes included accessibility of support, responsiveness to concerns, and feelings of empowerment and inclusion. Additional markers included trainee feedback at deanery trainee-rep meetings, evidence of resolved issues (e.g. supervision, rota and induction changes), and qualitative reports of improved interpersonal relationships.

Learning

Forum led to improved induction, practical solutions for on-call rota pressures, clearer distinction between training and service lists, and escalation of ward staffing and exception-reporting issues. Trainees reported feeling heard and supported. We learned that psychological safety is created through many small, dependable responses rather than a single intervention.

Next steps

Embedding these sessions routinely, formalising links with trust-wide “Freedom to Speak Up” and sharing the model with other departments and trusts. Anticipated benefits include

improved GMC, NHS and TEF survey outcomes, and improved patient care and safety. Incorporating wellbeing representative post in Deanery for sustainability.

Key message

Structured “Speak Up” sessions are a simple, scalable intervention to improve psychological safety, trainee experience, and service quality. Embedding such forums within routine practice can foster a culture of openness, resilience, and shared responsibility for improvement.

References

1. https://www.youtube.com/watch?v=2PM5N2SWS0g – Is it Safe to Speak Up at work? – WorkLife with Adam Grant

2. https://elearning.rcog.org.uk/catalog?pagename=Race-equity-in-the-workforce

Submission ID: 78

Title: Blankets for Ipswich - connection, creativity, community

Presented by: Azita Ahmadi, Foundation Year 1 Doctor, South East; Amy Falla, Socially Engaged Artist, Facilitator, East of England

Poster presentation section 3: 14:05 - 15:15 learning, leadership and inclusion

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: Person centred practice; System working
Relevant enhance cross-cutting themes: Wellbeing

Background

Blankets for Ipswich, organised by volunteer ambassadors as part of larger project “Blankets for the World” by Craft Forward CIC, is a collaborative community project intended to positively impact wellbeing. The project meets a combination of 3 of the 5 ways to wellbeing outlined in “Make Every Contact Count” toolkit – social connection, learning, giving.

Intervention

A series of 5 free workshops were organised in Ipswich in 2025 towards collective goal of creating blankets to donate to Lighthouse Women’s Shelter and Suffolk Refugee Support (SRS). Knitting and crocheting materials were provided at all events and participants with any level of experience were encouraged to attend. Events were advertised through social media, local news articles, physical flyers in local establishments (e.g. library, mental health café). Although no formal teaching, the more experienced in the group as well as the facilitators of

project helped beginners to learn and feel involved. During the workshops, participants made squares to be stitched into collaborative blankets or worked on their own blankets to be donated. In later workshops, participants worked together to stitch squares together.

Conclusions

Community initiatives are vital to signpost towards, in combination with or (with waiting lists getting longer) often awaiting other conventional therapies. These initiatives allow people at risk of social isolation to find connection and protective factors in safe spaces. Informal feedback from participants shows the social impact these projects can have; they remarked on connections formed with likeminded people, inclusivity and impact of making to give to a good cause. Based on success of 2025 project, it will be running again this year supporting SRS again. Healthcare staff, clinical and non-clinical, particularly social prescribers, can gain from learning about and getting involved with or even organising projects like this, especially if new to a locality. Signposting towards community projects they may be interested in is a quick and easy way to connect with patients. Looking in local libraries, and local news sites you can often find similar free initiatives – we can create clear and updated signposting towards these on bulletin boards in GP practices and hospitals.

Submission ID: 79

Title: From Innovation to Impact: AI-enabled Decision Support in NHS Clinical Pathways

Presented by: Hussain Al-Hilali, Foundation Year 2 Doctor, North West

Short oral presentations session 3: 14:05 - 15:15 innovative ideas and doing things differently: environmental sustainability, system working and digital pathways

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: System working; Population health; Person centred practice
Relevant enhance cross-cutting themes: Digital; Leadership

Authors: Dr Hussain Al-Hilali, Dr Cameron Ashraf

Background

Artificial intelligence (AI) is increasingly promoted as a solution to diagnostic delay, workforce pressure and variation in care. However, its value should be judged by real-world clinical impact rather than technical performance alone. This evidence synthesis explores how AI is being implemented in NHS pathways, and what this means for safe, person-centred and multiprofessional practice.

Methods

A narrative review was undertaken using publicly available UK evidence from NHS England and national professional bodies. Sources were selected where they described AI deployment in clinical practice, measurable patient or service outcomes, or clinician readiness for AI adoption.

Results

The strongest current evidence comes from pathway-specific diagnostic support. In acute stroke care, NHS England reported a real-world evaluation including 452,952 stroke patients across 107 hospitals. Following implementation of AI-supported CT interpretation at 26 evaluation hospitals, 15,377 patients had scans reviewed using AI. At participating sites, thrombectomy rates doubled from 2.3% to 4.6%, while primary stroke centres using AI saw a 64-minute reduction in door-in-door-out transfer time.

In cancer diagnostics, AI-supported chest imaging in Greater Manchester has been reported to support over 40,000 X-rays per month, with potential high-risk findings relayed to clinicians in under one minute. NHS England reported that up to 1,400 CT scans and 1,000 two-week-wait referrals had been avoided, suggesting potential benefits for triage, capacity and patient flow.

However, implementation remains limited by workforce confidence and digital infrastructure. A Royal College of Physicians survey found that 70% of physicians supported wider NHS AI implementation, but only 8% felt very confident using clinical AI tools, and 79% felt they needed training.

Conclusion

AI is already showing measurable NHS impact when embedded into defined clinical pathways. Its safest role is as clinician-facing decision support, supported by training, governance, interoperability and multiprofessional leadership.

References

NHS England, 2025. Stroke AI implementation report.

NHS England North West, 2025. AI-supported lung cancer pathway report.

Royal College of Physicians, 2026. AI in healthcare survey.

Submission ID: 80

Title: Is VR a Useful Tool in Developing Communication Skills in Foundation Doctors?

Presented by: Elinor French, Foundation Year 1 Doctor; Filipa Silva, Foundation Year 1 Doctor; Wales

Poster presentation section 3: 14:05 - 15:15 learning, leadership and inclusion

Affiliation to enhance: Currently in an enhance enable programme
Relevant enhance domains: Person centred practice; Complex multimorbidity; Social justice and health equity
Relevant enhance cross-cutting themes: Digital

Background

Effective communication is a fundamental skill for foundation doctors across all clinical environments and specialties. Early postgraduate clinicians are required to communicate clearly and compassionately with patients, relatives, and multidisciplinary teams in a wide range of settings, often whilst managing uncertainty, complexity, and time pressures. Traditional approaches to communication skills training, including bedside teaching and role-play simulation, can be limited by variable clinical exposure, limited teaching opportunities, and learner confidence. Virtual reality (VR) offers an immersive and interactive educational environment which may provide a scalable and psychologically safe alternative for developing communication skills in early postgraduate training.

Aim

To evaluate the perceived usefulness and impact of VR-based communication skills training among foundation doctors.

Methods

We conducted a prospective pre- and post-intervention study involving foundation doctors who completed a VR communication skills module. The module focused on scenarios commonly encountered during foundation training, including difficult conversations, communicating uncertainty, escalation of care discussions, and providing clear information to patients and relatives.

Participants completed questionnaires before and after the VR experience assessing self-reported confidence across key communication domains. Data collection is ongoing. Pre- and post-module responses will be compared to evaluate changes in confidence and perceived preparedness for real-world clinical communication. Participant feedback regarding educational value, accessibility, realism, and acceptability of VR as a training method will also be analysed.

Outcomes

This poster will demonstrate the feasibility and perceived educational value of VR simulation as a tool for communication skills training in foundation doctors. The project aligns with the Enhance programme's focus on innovative, person-centred, and multidisciplinary learning approaches that prepare clinicians for complex healthcare environments.

Findings from this work may help inform the future integration of immersive technologies into foundation training and support further research exploring the impact of VR-based education on objective communication performance, learner wellbeing, and patient-related outcomes.

Co-authors: Dr Elinor French, Dr Filipa Silva

Supervisor: Dr James Kilbane

Submission ID: 81

Title: On Time, Every Time: Improving Timely Administration of Parkinson's Disease Medications

Presented by: Isabella Hetherington, Foundation Year 1 Doctor; Tomiwa Adebowale, Foundation Year 1 Doctor; London

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Digital; Leadership

Authors

Dr Isabella Hetherington MBChB, Dr Tamiwa Adebowale MBChB, Dr Tamjeed Umar MBChB, Anthony Drexel BSc RN, Dalia Choudhury, Mahesh Parne

Background

Parkinson's disease (PD) medications are time-critical, and delayed administration is associated with worsening motor symptoms, aspiration, falls, prolonged hospital admission, and Parkinsonism–Hyperpyrexia Syndrome. Despite national guidance and the Parkinson's UK Every Minute Counts campaign, baseline audit data at Homerton Healthcare NHS Foundation Trust demonstrated suboptimal rates of timely medication administration for inpatients with PD.

Aim

To improve the proportion of PD medications administered within 30 minutes of their prescribed time and enhance patient-centred inpatient care through sustainable ward-based interventions.

Methods

A quality improvement project was undertaken on an elderly care ward between August 2025 and January 2026. Monthly audit data were collected for all prescribed PD medications. Following multidisciplinary staff engagement, a series of low-cost interventions were introduced in December 2025:

- Purple bedside visual prompts identifying patients with PD.
- Programmable alarm devices to alert staff when medication administration was due.
- Enhanced communication regarding time-critical medications during nursing handovers and safety huddles.

Interventions were developed collaboratively between medical, nursing, and ward teams to strengthen shared responsibility and improve system-wide awareness of medication prioritisation.

Results

Baseline data from August to November 2025 demonstrated that 44–55% of PD medications were administered within the target timeframe. Following implementation of interventions, timely administration increased to 66% in December 2025, with sustained improvement averaging 62% across December and January. Staff feedback demonstrated improved awareness of time-critical medications, greater confidence in prioritisation, and strengthened multidisciplinary communication.

Discussion

This project demonstrates that simple, scalable interventions can meaningfully improve medication safety and patient-centred care for people with PD. The use of digital alarm prompts and structured communication strategies supported collaborative leadership and promoted shared accountability across professional groups. These findings highlight the value of low-cost system interventions in improving healthcare quality without increasing workload burden.

Conclusion

Targeted multidisciplinary interventions improved the timely administration of PD medications in an acute inpatient setting. This project supports the wider adoption of practical, digitally supported strategies to enhance patient safety, teamwork, and quality of care for people living with Parkinson’s disease.

References

Parkinson's UK. Every Minute Counts.

NICE Guideline NG71: Parkinson's Disease in Adults.

Parkinson's UK. Time Critical Medication Guidance.

Submission ID: 83

Title: Getting It Right the First Time: Breast Day Case Audit

Presented by: Malathi Jabanathan, Higher Trainee Doctor, Midlands

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; System working
Relevant enhance cross-cutting themes: Wellbeing; Transformative reflection

Dr Malathi Jabanathan ST6 (Speaker), Dr Matthew Wiggley CT3, Dr Beth Hancox CT4

Laura Staniland RN, Elizabeth Wright RN, Dr Srini Magham Consultant,

Kings Mill Hospital, Sherwood Forest Hospitals Trust

Introduction

The British Association of Day Surgery recommends that 95% of Wide Local Excisions (WLE) and 50% of mastectomies are performed as zero-night-stay cases.1 Many hospitals struggle to achieve this Gold Standard. This audit assessed Kings Mill Hospital's performance, identifying anaesthetic factors that could be optimised to improve this. A re-audit demonstrated significant improvements in same day discharge rates in both categories, though remained short of the Gold Standard. Methods: Data was collected from 54 cases including: patient demographics, choice of anaesthetic agents, analgesia, all possible reasons for delayed discharge.

Recommendations were made on optimising analgesia, risk stratifying patients for earlier operative start time and reduced use of anxiolytics and explore other logistics. A re-audit was performed encompassing 50 new patients and data compared.

Steps taken

No unwanted sedatives, Attempted risk stratification, Extended daycase trolley hours

Results

Same day discharge rates for WLEs and mastectomies showed significant improvements, increasing to 74% and 40%, respectively (c.f. 41% and 25%), though still falling short of national targets. A reduction in drowsiness , nausea, and oxygen requirement was associated with improved discharge rates. However, no statistically significant differences in admission rates were seen on comparisons of factors such as analgesia, anaesthetic agent or airway used. Surgical factors and new medical issues became the main reasons for admission.

Conclusion

The improvement in rates of discharge correlated with reductions in the use of sedatives. Additionally, extended Day Case Trolleys opening hours gave patients longer to recover and reduced the 'pyjama paralysis' of beds. Discussions with stakeholders revealed barriers to achieving the Gold Standard included difficulty listing complex patients first due to wire insertions and reduced staffing in the evenings, preventing discharge.

References:

1. Irvine T, MacNeill F. Breast Surgery GIRFT Programme National Specialty Report 2021 [Internet]. Birmingham: Getting It Right First Time; 2021 Sep [cited 2025 Aug 27]. Available from: https://gettingitrightfirsttime.co.uk/wp content/uploads/2021/09/BreastSurgeryReport-Jul21p.pdf

Submission ID: 85

Title: Urine Culture Microscopy Rejections in ED: The importance of communication across teams

Presented by: Nour Omera, Foundation Year 1 Doctor, Northern Ireland

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working; Environmental sustainability
Relevant enhance cross-cutting themes: Wellbeing; Leadership

The first urine sample collected in the Emergency Department (ED) is highly valuable, as repeat sampling decreases the probability of organism isolation after commencing empirical antibiotics. Urine culture and microscopy (UCM) samples comprised 50% of total rejections in Altnagelvin hospital in November 2025, with the ED ward being the most significant source for sample rejection (27% UCM rejection rate).

Analysis of ED UCM rejection causes reveals that underfilling is the highest offender, comprising 85% of rejections. To rectify this, discussion was held with the project lead (Dr. Ismail Fawaz, infectious disease consultant) and the biomedical lead (Mr. Martin Robinson) around correct collection technique, common errors and laboratory expectations.

Intervention centred on providing a teaching session targeting all rejection categories in early February 2026, holding conversations with ED HCAs, the creation of a poster with visual instructions, and the clear labelling of monovette containers.

A relative reduction of 44% in ED UCM rejection rate was consequently observed in February, from 28% to 15%. The reduction was observed across all rejection categories, particularly underfilling, for which the ED UCM rejection rate fell from 23% to 15%. The improvement persisted in the following month, with an ED UCM rejection rate of 18% in March. A second cycle was commenced in late April, with a teaching session provided by the biomedical lead directly.

The project emphasized the importance of cross-departmental communication between the doctors, laboratory lead, nurses and practice educators to ensure team synergy. Moreover, the utility of concise visual guidelines for the nursing team was highlighted, whose feedback indicated they either were not aware of the microbiology manual available on the hospital intranet, or found it too verbose.

The authors are currently scoping the expansion of this approach to other wards and other microbiology sample types, as well as incorporating the created teaching materials into the regular training of the nursing team.

Submission ID: 87

Title: Irradiated Blood Transfusion QIP

Presented by: Chetana Chava; Foundation Year 1 Doctor, South East

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: System working; Environmental sustainability
Relevant enhance cross-cutting themes: Wellbeing; Digital

To ensure compliance with irradiated blood transfusion guidelines are met to maintain patient safety and prevent adverse transfusion-associated reactions such as graft versus host disease, a rare but potentially fatal complication. Correct identification of patients requiring irradiated blood products is crucial. Additionally by raising awareness, it avoids unnecessary wastage of irradiated blood to ensure it is reserved for those who require it as well reducing cost e.g. for processing.

Aims include assessing compliance with the identification and provision of irradiated blood products, reviewing the indications for irradiation, as well as analysing the number of irradiated units transfused and any gaps in prescribing and administration practice with a focus to also improve patient safety by increasing staff awareness.

Data was retrospectively collected with help from the hospital blood bank over period of one-year from January 2025 to January 2026. A proforma was used to standardise data collection, and results were entered and analysed using Microsoft Excel.

A total of 25 patients were included in the data collection. Patient ages ranged from 31 to 86 years, with a median age of 64 years. The results demonstrated 100% compliance in providing irradiated blood products to patients with a documented indication, reflecting good adherence to patient safety standards. However, 14 patients (56%) received irradiated blood transfusion despite having no formal indication for requiring irradiated blood products. The number of irradiated units transfused ranged from 2 to 21 units per patient, and three patients received more than 10 irradiated units.

The findings highlight both strengths and areas for improvement. While compliance for indicated patients was excellent, overuse of irradiated blood products represents avoidable wastage and increased cost. Standard red cell units cost £186.51 compared with £199.44 for irradiated units, representing an additional cost of £12.93 per unit.

Proposed interventions include improved patient identification through electronic alerts, stickers in patient notes, clearer intranet guidance regarding indications, patient counselling, and the use of irradiated blood alert cards or bracelets. Improved staff awareness and clearer identification systems may help reduce inappropriate prescribing, minimise wastage, improve stock management, and maintain high standards of patient safety.

References

https://b-s-h.org.uk/guidelines/guidelines/guidelines-on-the-use-of-irradiated-blood-components

https://bts.org.uk/wp-content/uploads/2016/09/Irradiation_BJH_2011.pdf

Submission ID: 88

Title: Addressing the climate emergency and a healthcare system in crisis; how can we optimise the blood culture pathway in microbiology to support healthcare sustainability?

Presented by: Laura Shepherd, Locally Employed Doctor, North East and Yorkshire

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Previously took part in an enhance explore programme

Relevant enhance domains: Environmental sustainability
Relevant enhance cross-cutting themes: Transformative reflection; Leadership

Author: Dr Laura Shepherd

Background/Problem

The detrimental impact of human activity on the environment and planetary health, disrupting the delicate balance of the natural world, is adversely effecting human health and threatening the longevity of human existence. Recognition of the interconnected nature of the health of the planet, and those who inhabit it, is key to understanding and developing a sustainable healthcare system. Reducing the carbon footprint of the NHS is a responsibility we all share, prompting the reflection and review of our actions and practices.

Aim

To review the pre-analytical elements of blood culture pathway in Medical Microbiology at North Cumbria Integrated Care NHS Foundation Trust (NCIC) to determine how it can be optimised to support healthcare sustainability.

Context

Blood culture sampling and analysis is an integral part of the diagnosis and management of bloodstream infections and sepsis. At NCIC, data relating to the blood culture pathway is routinely collected for various purposes, which includes internal monitoring/review, and local/national audit.

What we did

Reflecting on individual and departmental practices in the context of environmental and healthcare sustainability, a review of the existing routinely collected information/data from January, March, and November 2025 was completed. Local data was compared with national standards/guidelines and laboratory requirements for specimen analysis to help identify areas for improvement.

Measures

Number of blood culture bottles received, time to be loaded (in a <4 hour window), and volume (specifically if optimal or very under filled) were reviewed.

Results/Learning

- In November 2025, 55.7% of samples at the Cumberland Infirmary had the optimal fill of blood (62% in March, 2025, and 54% in January 2025).
- Insufficient quantities and volumes were identified as areas for optimisation

Next Steps

- Written informatics/posters in clinical areas
- Clinical skills training/refresher courses
- Blood culture pathway inclusion in departmental inductions

Key Learning

Under filling and sending insufficient sample quantities has direct and indirect negative consequences for the patient and the environment. In addition to potential harm to the patient, longer hospital stays, inappropriate use of medication and treatment, and unnecessary investigations all contribute negatively to our carbon footprint.

Submission ID: 89

Title: Greening Lean: Overcoming barriers to integrating environmental practices in surgical Lean management projects: A scoping review

Presented by: Mel Hemiel Sarker, Foundation Year 2 Doctor; Emily Deng, Foundation Year 2 Doctor; London

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Population health; System working; Environmental sustainability
Relevant enhance cross-cutting themes: Transformative reflection; Leadership

Authors:

Josh P. Kotecha, Samruddhi Tagalpallewar, Diya Banerjee, Mel H. Sarker, Emily Deng, Christie Tsang, Thejas K, Laure de Preux

Background

Healthcare systems face increasing pressure to improve operational efficiency while reducing environmental impact. Operating theatres are major contributors to healthcare-associated carbon emissions and waste generation. Lean management methodologies have demonstrated success in improving efficiency in surgery, but their role in promoting environmental sustainability remains underexplored.

Methods

A scoping review was conducted in accordance with PRISMA-ScR guidelines to evaluate the application of Lean methodologies in improving environmental sustainability within surgical settings. Searches of MEDLINE, EMBASE, HMIC, SCOPUS, EBSCO, and Cochrane databases were performed alongside a structured grey literature review. Studies assessing Lean interventions with environmental outcomes in surgical practice were included. Data were extracted on Lean principles applied, environmental outcomes, and barriers to implementation.

Results

From 5,011 identified records, 24 academic articles and 13 grey literature sources met inclusion criteria. Lean methodologies including Lean Six Sigma, Value Stream Mapping, DMAIC, 5S, Kaizen, and PDSA cycles were associated with reductions in surgical waste, instrument usage, energy consumption, anesthetic gas emissions, and operating theatre inefficiencies. Several studies demonstrated measurable environmental benefits, including reductions in regulated medical waste by up to 61%, annual carbon savings exceeding 110 tonnes CO2e, and significant reductions in disposable instrument use and energy consumption. Four major barriers to implementation were identified: lack of individual and institutional responsibility, rigid hierarchical healthcare structures, insufficient multidisciplinary collaboration, and limited education and awareness regarding sustainability practices.

Conclusion

Lean methodologies offer a promising framework for integrating environmental sustainability into surgical practice while maintaining operational efficiency. However, wider implementation requires stronger leadership, collaborative culture change, improved sustainability education, and standardised environmental outcome metrics. Further multicentre and longitudinal studies are needed to validate sustainable Lean frameworks across healthcare systems.

References

Rizan C, Bhutta MF. Strategy for net-zero carbon surgery. Br J Surg. 2021;108(7):737–739.

Kagoma Y, Stall N, Rubinstein E, et al. People, planet and profits: the case for greening operating rooms. CMAJ. 2012;184(17):1905–1911

Submission ID: 96

Title: Improving Compliance with Head-of-Bed Elevation Guidelines in Mechanically Ventilated Patients: A Quality Improvement Project

Presented by: Ibraheim Sheikh, Foundation Year 2 Doctor; Edward Kim, Foundation Year 1 Doctor; East of England

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: Environmental sustainability
Relevant enhance cross-cutting themes: Wellbeing

Background

Ventilator-associated pneumonia (VAP) remains a significant cause of morbidity and mortality in critically ill patients. The National Institute for Health and Care Excellence (NICE) recommends elevating the head of the bed to 30–45° in intubated and mechanically ventilated patients to reduce the risk of VAP. Despite clear guidance, adherence can vary due to both systemic and individual factors. This project aimed to audit compliance with this recommendation within the Intensive Therapy Unit (ITU) at Princess Alexandra Hospital NHS Trust and to evaluate the impact of targeted educational interventions on practice.

Methods

A prospective audit was conducted over a four-week period assessing head-of-bed elevation in mechanically ventilated patients. Bed angle was measured at random points during the day using a digital inclinometer application. Data were collected on whether positioning fell within the recommended 30–45° range. Following the initial audit cycle, a multifaceted educational intervention was implemented, including a departmental teaching presentation, bedside demonstrations with nursing staff, and visual reminder posters displayed throughout the ITU. A re-audit was then performed using the same methodolog to assess the impact of the intervention.

Results

Baseline compliance with the NICE recommendation was 80%. Staff feedback highlighted uncertainty regarding accurate angle measurement and variable awareness of the evidence underpinning the guideline. Following the educational intervention, compliance improved to 92%, demonstrating a meaningful and sustained improvement in practice.

Conclusion

This audit highlights the effectiveness of targeted education, visual prompts, and practical demonstrations in improving adherence to evidence-based guidelines in critical care. Maintaining head-of-bed elevation at 30–45° is a low-cost, high-impact intervention in VAP prevention and should be embedded into routine ITU practice, supported by ongoing education and regular audit cycles.

Submission ID: 98

Title: Bone scintigraphy, Prostate cancer, Diagnostic stewardship, Financial burden, Environmental sustainability

Presented by: Jin Ren Lau, Foundation Year 2 Doctor; Ker Yin Tee, Foundation Year 2 Doctor; North West

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: Environmental sustainability; System working
Relevant enhance cross-cutting themes: Transformative reflection

Authors: JinRen Lau, KerYin Tee, Saeid Haghdani, Ketan Agarwal

Urology Department, East Lancashire Hospitals NHS Trust, United Kingdom

Background

Bone scintigraphy remains commonly used in prostate cancer staging despite national guidance recommending against routine use in Cambridge Prognostic Group (CPG) 1–2 patients, while uncertainty persists regarding its role in CPG 3 disease. Unnecessary imaging exposes patients to avoidable radiation, prolong diagnostic pathways, and increase financial and environmental burden. Reducing low-value investigations aligns with Greener NHS targets and Net Zero NHS ambitions by minimising unnecessary carbon-intensive diagnostic activity.

Aim

To evaluate the appropriateness of bone scan against guideline standards and assess diagnostic yield across risk groups. To identify opportunities for sustainable, evidence-based improvement in prostate cancer staging pathways.

Methodology

This retrospective observational study was conducted at East Lancashire Hospitals NHS Trust as part of departmental clinical governance and MDT reflective practice. First 100 patients with newly diagnosed prostate cancer who underwent bone scintigraphy for initial staging from January 2024 were included. Data collected included PSA, Gleason score, bone scan findings, symptom status, and Cambridge Prognostic Group (CPG) classification. Imaging requests were benchmarked against national guideline standards. Analysis included bone scan positivity rates across risk groups, guideline compliance, and estimated avoidable imaging costs.

Results

Overall bone scan positivity was 7%. No metastatic disease was identified in CPG 2-4, PSA <20 ng/mL, or Gleason ≤7. All positive scans occurred in CPG 5. Findings suggest routine imaging in intermediate-risk disease, particularly CPG 3, have limited diagnostic value within our population. Local estimated imaging costs suggested potentially avoidable expenditure of up to £482 per patient when follow-up SPECT-CT imaging was required.

Next Steps

This study prompted reflective MDT discussion regarding imaging thresholds and diagnostic stewardship. Planned interventions include clinician education, reinforcement of guideline-based imaging pathways, and development of a multicentre collaborative audit exploring CPG 3 metastatic risk.

Key Learning Points

1) Bone scintigraphy has a low diagnostic yield in low- to intermediate-risk prostate cancer groups, while local practice suggests overutilisation.

2) Sustainable healthcare requires reflective review of routine investigations and reduction of low-value imaging.

3) MDT learning can support environmentally and financially responsible care by reducing unnecessary imaging, minimising radiation exposure, supporting Greener NHS ambitions through lower resource utilisation, and reducing NHS costs.

Submission ID: 99

Title: Improving equity in urine drug screening on a general adult female psychiatric ward

Presented by: Florence Onabanjo, Foundation Year 1, London

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working; Social justice and health equity; Population health
Relevant enhance cross-cutting themes: Digital; Leadership

Rationale

In a general adult female mental health ward in North East London, a significant proportion of patients at presentation have comorbid drug-induced mental illness or polysubstance misuse. Nursing staff are normally responsible for implementing urine drug screens on patients.

Aim

To align with the trust Risk Assessment schedule, a quality improvement project was implemented to double the number of patients on the ward undergoing urine drug screening within 7 days of admission from 25 to 50% over a 1-month interval

To increase the frequency of documentation of urine drug screen refusals on Rio from 0-90% over a 1-month interval

Methods

A qualitative stakeholder analysis of relevant multidisciplinary team members was conducted, which informed the change driver, which set the direction of the Plan-Do-Study-Act (PDSA) models that were implemented. Changes included: data-driven and context-led ward-based tutorial on the significance of urine drug screening in the ward, matron announcement of a new universal UDS, urinalysis and pregnancy triple assessment, followed by design and dissemination of trust Risk assessment Schedule policy converted into an infographic and placed in the nursing station

Outcomes

9 weeks of mixed qualitative and quantitative data were collected. Data demonstrated a 40% increase (25% to 35%) in the proportion of patients undergoing UDS within the timeframe, with efficiency in drug screening increasing significantly, from a median of 6 days between admission and screening to 1 day.

Evidence for impact

Baseline data suggested that urine drug screens were conducted solely on black and ethnic minority patients, despite white British patients on the ward with a history of polysubstance misuse. QIP implementation completely closed that gap, improving equity in drug screening on the ward. MDT Stakeholder involvement was a key agent in implementing change, particularly from the ward matron. Feedback suggests an appetite for a culture of data and clinical governance, where several staff expressed interest in continuing to participate in the

QIP, including matron-led tutorials to support nurse digital literacy with centralised technologies such as Rio. Further cycles should incorporate education on bias in clinical decision-making and implications on patient risk and prognosis in psychiatry.

Submission ID: 100

Title: Transforming care for older adults with heart failure, frailty and complex multimorbidity: co-development of a holistic multidisciplinary pathway

Presented by: Shirley Sze, Higher Trainee Doctor, Midlands

Short oral presentations session 3: 14:05 - 15:15 innovative ideas and doing things differently: environmental sustainability, system working and digital pathways

Affiliation to enhance: Not affiliated
Relevant enhance domains: Complex multimorbidity; Person centred practice; System working
Relevant enhance cross-cutting themes: Transformative reflection; Wellbeing

Background

Older adults with heart failure (HF), frailty and multiple long-term conditions (MLTC) often receive fragmented, disease-focused care, leading to poor quality of life (QoL) and recurrent admissions. Our stakeholder work (1) identified significant unmet needs and mismatch between patient priorities (QoL) and clinician goals (survival).

Aim

To co-develop, implement and evaluate a holistic pathway to improve QoL in this population.

What we did

Service mapping to define patient journeys and bottlenecks; co-development of a 12-week holistic pathway with patients, carers, professionals and service managers, using the Six Essential Steps for Quality Intervention Development (6SQuID) framework. We tailored our implementation strategies using Consolidated framework for implementation research (CFIR). Iterative PDSA cycles refined pathway flow, workload and efficacy.

The pathway comprised individualised exercise training, dietetic counselling, medication optimisation, environmental & social support and integrated HF & comorbidity management, delivered by an MDT of healthcare professionals. All patients had a holistic (clinical/function/ psycho-cognitive/social) assessment, MDT discussion and delivery of individualised care plan via one-stop-clinic with 2-weekly follow ups. Co-created resources included: patient booklet,

implementation guide, care plan templates and a digital portal to automate GP communications.

NHS REC/R&D approvals obtained.

Results

Pathway implementation across 2 NHS hospital trusts to 56 HF patients with frailty (median age 82 years; median five comorbidities).

Process measures

96% patients completed all compulsory pathway contacts; MDT involvement: physiotherapist (100%), dietician (92%), OT (75%), pharmacist (56%), geriatrician (40%) and HF specialist (34%) input.

Balancing measures

50 minutes MDT time/week/5 patients, mean clinic duration 96 minutes/patient, no significant pathway-related adverse events.

Outcomes improved

HF-QoL (KCCQ-12 40.4 to 62.9); General QoL (EQ-5D 0.45 to 0.66); physical function (SPPB 3.9 to 5.7); frailty: (Edmonton Frail Scale 9 to 6). Six-month admissions and bed-days were lower post versus pre-intervention (24 vs 37; 239 vs 394).

Interviews (n=46) showed strong acceptability; patients valued “all experts in one place”, “materials are easy to follow.

Estimated net saving was £750/patient.

Next steps / Take-home message

Community implementation is planned to increase pathway reach, impact and sustainability. Our holistic pathway is feasible, acceptable and potentially cost-saving, offering a scalable model for person-centred, multidisciplinary MLTC care delivery.

Reference

Krishnan S, Gogoi M, Tarrant C, Conroy S, Clayton L, Squire IB, Sze S. Healthcare needs and priorities of older people living with heart failure and frailty: a multi-perspective study of patients, carers and clinicians. BMC Geriatr. 2026 Jan 7;26(1):163.

Authors: S Sze, S Krishnan, K Guha, PR Kalra, L Clayton, C Tarrant, S Conroy, IB Squire

Submission ID: 101

Title: Implementation of a Waste Reduction Initiative in a Sexual Health Clinic: A Quality Improvement Project

Presented by: Malika Mohabeer Hart, Consultant; Edward James, Foundation Year 2 Doctor; London

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: Environmental sustainability; System working; Social justice and health equity
Relevant enhance cross-cutting themes: Wellbeing

Edward James, Michal Kawka, Malika Mohabeer Hart

Introduction

Sustainability in healthcare is a growing priority, with NHS England committed to achieving net-zero carbon emissions1. Clinical waste disposal is a significant financial and environmental burden2,3. This quality improvement project (QIP) aimed to reduce waste, optimise segregation, and assess the feasibility of reusable speculums in a sexual health clinic.

Methods

A two-cycle prospective audit was conducted across 20 clinic days at a sexual health service in London. In the first cycle, waste weight was measured in black (non-clinical) and orange (clinical) bins. An educational intervention, including staff training and updated bin signage, was introduced. The second cycle measured waste post-intervention. Waste weight, CO2 emissions associated with disposal and per annum costs were estimated at a service level1. Additionally, the financial and environmental impact of reusable speculums was assessed.

Results

Following intervention, non-clinical waste weight annual projection increased from 0.96 to 1.77 tonnes per year, while clinical waste decreased from 2.4 to 1.74 tonnes per year, indicating potential improved segregation. Estimated carbon savings were 67.7%, reducing CO_2 emissions from 4,689kg to 1,515kg per annum. Financially, clinical waste disposal costs approximately £800 per tonne, leading to an estimated annual saving of £520 due to reduced clinical waste volume For reusable speculums, a projected carbon reduction of 382kg CO_2 per year.

Discussion

This initiative demonstrates that targeted interventions can enhance waste segregation, reduce costs, and improve sustainability in sexual health services. While reusable speculums have potential environmental benefits, financial viability depends on sterilisation costs. Future work will focus on assessing long-term savings and scaling sustainable practices.

References

1.Scarfe, M. (2011) Introducing recycling into the operating theatres. Available at: https://map.sustainablehealthcare.org.uk/oxford-radcliffe-hospitals-nhs-trust/introducing-recycling-operating-theatres.

2.NHS England (2023) NHS clinical waste strategy. Available at: https://www.england.nhs.uk/long-read/nhs-clinical-waste-strategy/

3.Nicholson, J. (2024). Understanding clinical waste. Community Health Partnerships. https://communityhealthpartnerships.co.uk/tenants/understanding-clinical-waste/

Submission ID: 102

Title: Post-Operative Dietary Advice: A QIP to Improve Ward Team Knowledge and Practice

Presented by: Asad Kaiser, Foundation Year 1 Doctor, East of England; Sakina Abrar, Foundation Year 1 Doctor, London

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; Complex Multimorbidity; Population health
Relevant enhance cross-cutting themes: Wellbeing

Background

Post-operative dietary management is fundamental to surgical recovery, yet no formal teaching on trust guidance exists for ward teams. Four standardised diet stages are used: water only, free fluids, low-fibre, and normal, each with specific indications and dietitian referral thresholds. Inappropriate diets or dietary progression carries significant clinical risk; prolonged restriction contributes to malnutrition and delayed recovery, whilst premature advancement risks anastomotic complications and aspiration. Timely dietitian involvement is equally critical, yet referral thresholds are poorly understood. Unclear dietary plans are a cause for extensive confusion between both doctors and the nursing team. Concern regarding inconsistent ward

round documentation and uncertainty over the diet of post-operative patients prompted this two-cycle PDSA Quality Improvement Project.

Methods

A mixed-methods survey was distributed to surgical ward teams comprising six Likert confidence statements, ten knowledge MCQs, and open-ended qualitative questions. Furthermore, 113 ward round entries for post-operative patients were reviewed against trust dietary guidance. The intervention is a structured teaching session to the ward team with resource distribution.

Results

Thirty responses were received (70% Foundation Year doctors, 25% Core Trainees, 5% Registrars). Self-rated confidence was low across all domains (15–35% agreeing or strongly agreeing). Zero percent of respondents were aware the trust ward information guidance existed. MCQ performance averaged 57.9%. As an example, the weakest areas were the evidence base for black coffee in reducing time to first bowel movement (30% correct) and dietitian referral thresholds (50% correct). Qualitative responses consistently described a complete absence of formal teaching. Ward round review found only 25.6% of entries met trust standard, with 39.5% containing no dietary documentation at all. Non-standardised terms such as “soft diet”, “sloppy diet”, and “eat and drink as tolerated” were frequently identified. We delivered the data analysis and teaching to the surgical teams, we are currently in the progress of cycle 2.

Key Messages

Significant gaps exist in ward team knowledge, confidence, and documentation practice. Nearly 40% of post-operative patients had no dietary plan recorded, representing a patient safety risk. Four recommendations arise: mandatory diet documentation added to the surgical ward round at trust level; a laminated quick reference card at ward nursing stations; post-operative diet teaching embedded in the Foundation Year induction programme; and formal trust audit registration ahead of Cycle 2.

Submission ID: 103

Title: Simtegrated Care: A Novel Cross-Sector Simulation Model to Improve Systems-Based Understanding and Interprofessional Learning in Early Clinicians

Presented by: Emmanuel Edeh, Core Trainee / ST1-ST3 Doctor, East of England

Poster presentation section 2: 11:40 - 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Multiprofessional Foundation School Fellow

Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Leadership; Transformative reflection

Authors: Dr Charleen Liu (Simulation Lead, Multiprofessional Foundation School), Dr Emmanuel Edeh and Trevlyn Katsana (Fellows, Multiprofessional Foundation School)

Background / Problem

Transitions between primary and secondary care are recognised high-risk points for communication failure, fragmented care, and patient harm. Despite this, early postgraduate healthcare training frequently occurs within professional and organisational silos, limiting learners' understanding of the wider healthcare system and the impact of decisions across care interfaces. Educational approaches that support systems working and multiprofessional collaboration are increasingly needed to improve patient safety and continuity of care.

Aim

To pilot and evaluate a novel "Simtegrated Care" simulation model designed to improve understanding of cross-sector patient journeys, interprofessional roles, and systems-based practice amongst early clinicians.

Context

This pilot involved Foundation trainees including Foundation Doctors and trainee pharmacists within a multiprofessional simulation programme. Faculty included a General Practice Registrar, Emergency Department Consultant, Acute Medicine Consultant, Senior Pharmacists, and Pharmacy Technician.

The project aligned with Enhance domains of systems working and person-centred practice, with cross-cutting themes of leadership, transformative reflection, and multiprofessional workforce learning.

What We Did

We designed a longitudinal, cross-sector simulation following a patient journey from primary care to emergency and acute hospital care, and their transition back into the community. Learners participated in real-time simulated scenarios, clinical decision-making, multidisciplinary discussions, and facilitated reflective debriefs exploring communication, continuity, escalation, discharge planning, and interface challenges across healthcare settings.

Evaluation

Post-session evaluation used quantitative Likert-scale feedback and qualitative free-text responses to assess interprofessional learning, understanding of care transitions, and awareness of systems-based practice.

Results / Learning

Participants reported improved understanding of the patient journey across services and greater appreciation of professional roles and system pressures. Learners described enhanced insight into “how patients progress through care settings” and increased awareness of the need for collaboration between primary and secondary care.

Interprofessional learning scores demonstrated strong agreement that participants:

- learned useful skills from other professionals (6.5/7),
- had clearer understanding of professional roles (7.0/7),
- and developed stronger responsibility for the whole patient journey (6.8/7).

Sustainability / Next Steps

Future work will include expansion across additional healthcare professions and evaluation of behavioural impact on communication and transition-of-care practices. The model is low-cost, transferable, and adaptable to other integrated care and workforce learning settings.

Key Learning Points

Cross-sector “Simtegrated” simulation may address gaps in systems-based training by improving understanding of integrated care pathways, strengthening interprofessional collaboration, and supporting safer patient transitions through workforce learning.

Submission ID: 105

Title: Improving the Management of LGBT Patients Through Online Healthcare Education: A Quality Improvement Project

Presented by: Alec Letten, Foundation Year 2 Doctor, North East and Yorkshire

Short oral presentations session 2: 11:40 – 12:40 social justice, health equity and population health innovations

Affiliation to enhance: Previously took part in an enhance explore programme
Relevant enhance domains: Person centred practice; Social justice and health equity
Relevant enhance cross-cutting themes: Digital; Leadership

Background

Lesbian, gay, bisexual and transgender (LGBT) people have a higher prevalence of behaviours that may confer a risk to health [1]; however, healthcare professionals often lack knowledge and confidence when communicating with and managing these patients. This contributes to poor patient care, missed diagnoses and a reduction in healthcare seeking [2]. A lack of specific LGBT education may be responsible. Many medical students report insufficient LGBT training and express a desire for formal teaching [3]. This quality improvement project uses iterative PDSA cycles to deliver education to healthcare students and professionals nationally.

Method

A fishbone analysis identified potential interventions. These included an online lecture series on common conditions, a one-off session on leadership/advocacy, and an interactive case-based workshop. All sessions were delivered through the medical education platform ‘Mind the Bleep’ by LGBT clinicians. Outcomes were assessed via post-intervention questionnaires using mixed methods, including a Likert scale to collect quantitative data.

Results

Ninety-five responses were collected across three PDSA cycles. Percentage increases between pre- and post- intervention scores were observed in all primary outcomes: confidence (62.4%), knowledge (57.6%), communication (41.9%), and leadership (36.9%). A paired t-test identified statistical significance across all domains ($p<0.05$). Thematic analysis highlighted areas that were important to attendees: content, delivery and accessibility. Of the positive feedback, the clinical relevance was highlighted most frequently, with specific mention of an improvement in attendees’ communication skills (n=8). Improvements in delivery and accessibility were suggested, including requests for more attendee interaction (n=13) and to provide the slides in advance (n=7).

Discussion

These interventions improved participants’ ability to manage LGBT patients, thereby demonstrating that education can act as a catalyst to improve health inequalities. It also created practitioners who treat everyone with compassion and respect, and who can be flexible around the individual circumstances of each patient. Coproduction ensured teaching was person-centred and sensitive, and the use of online delivery was a sustainable option given it is low cost and easily accessible. This work is therefore scalable, and similar teaching could be made formally available for all health professionals, thus creating a larger and more diverse workforce who are confident in providing inclusive care.

References

1. Kann L, et al. Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9–12 — United States and Selected Sites, 2015. MMWR Surveill Summ. 2016;65. doi:10.15585/mmwr.ss6509a1

2. Crowe A, et al. Towards inclusive healthcare: evaluating knowledge, confidence and awareness of LGBTQ + health among Internal Medicine Trainees in London. BMC Medical Education. 2024;24(1):851. doi:10.1186/s12909-024-05827-y

3. Parameshwaran V, et al. Is the Lack of Specific Lesbian, Gay, Bisexual, Transgender and Queer/Questioning (LGBTQ) Health Care Education in Medical School a Cause for Concern? Evidence From a Survey of Knowledge and Practice Among UK Medical Students. Journal of Homosexuality. Published online February 23, 2017. Accessed August 2, 2025. https://www.tandfonline.com/doi/abs/10.1080/00918369.2016.1190218

Submission ID: 106

Title: Improving Early Recognition of Postoperative Delirium in Older People in PACU: A Quality Improvement Project

Presented by: Serena Chanoch, Foundation Year 1 Doctor, East of England

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Currently in an enhance enable programme
Relevant enhance domains: Person centred practice; Complex multimorbidity
Relevant enhance cross-cutting themes: Leadership

Background

Postoperative delirium is a common and serious complication after surgery, particularly in older patients, and is associated with increased morbidity, mortality, prolonged hospital stays, and long-term cognitive decline. It typically results from an interaction between baseline vulnerability and perioperative factors such as surgery and anaesthesia (Aldecoa et al., 2024). National guidance from NICE identifies patients aged 65 years and older, alongside those with cognitive impairment, hip fracture, or acute severe illness, as being at increased risk of delirium, and recommends routine assessment and early postoperative screening using validated tools (NICE CG103). The European Society of Anaesthesiology similarly emphasises early identification in the post-anaesthesia care unit (PACU), where delirium may first present. The British Geriatrics Society supports early recognition and systematic identification of delirium in at-risk hospitalised patients as part of good clinical practice. Despite this, implementation in routine practice remains inconsistent. The 4AT is a validated, rapid screening tool with high diagnostic accuracy for use in the PACU (Aldwikat et al., 2022).

Aim

The aim of this QIP is to increase the proportion of patients aged ≥65 receiving delirium screening using 4AT in PACU from 0% to >80% within 3 months.

Methods

A baseline audit was performed at Princess Alexandra Hospital to assess compliance with delirium screening in patients in PACU aged ≥65 years, which demonstrated a screening rate of 0%. Interventions were developed using a driver diagram and implementation is ongoing using a Plan–Do–Study–Act (PDSA) cycle. We aim to have initial results by the end of May, and to complete a second PDSA cycle, with necessary changes made, by the end of June.

Results

Pending.

Conclusion

This project highlights a clear gap between national guidance and current local practice in postoperative delirium screening for high-risk patients. Early implementation of a structured delirium screening pathway using the 4AT aims to improve recognition of delirium in PACU and support earlier intervention.

References

Aldecoa, C. et al. (2024) European Journal of Anaesthesiology, 41(2), pp. 81–108.

Aldwikat, R.K. et al. (2022) International Journal of Environmental Research and Public Health, 19(23), p. 16020.

NICE (2010, updated 2019) Delirium: prevention, diagnosis and management (CG103)

Author: Serena Chanoch

Submission ID: 109

Title: Evaluating the Real-World Impact of an Innovative Multiprofessional Generalist Leadership Programme

Presented by: Oluseun Adebawojo, Higher Trainee Doctor; Lawson Eya, Core Trainee / ST1-ST3 Doctor; East of England

Short oral presentations session 1: 09:30 – 10:30 enhance programme development & outcomes

Affiliation to enhance: Current enhance fellow East of England
Relevant enhance domains: System working; Complex multimorbidity; Person centred practice
Relevant enhance cross-cutting themes: Transformative reflection; Leadership

Authors: Dr O Adebawojo, Dr L Eya, Dr P Ande

Background

Healthcare systems are increasingly complex, requiring professionals who can work across traditional disciplinary boundaries, manage multimorbidity, and adopt systems-based approaches to care. Traditional profession-specific education may not fully prepare clinicians for these challenges. Enhance was developed to support multiprofessional generalist capability through immersive, experiential learning aligned to Enhance domains including systems working, person-centred practice, wellbeing, leadership, and transformative reflection.

Aim

To evaluate the real-world impact of the Enhance programme on professional practice, collaborative working, and systems-based care, while identifying lessons for evaluating complex educational interventions.

Context

Enhance is a multiprofessional leadership programme delivered across the East of England involving early-career healthcare professionals from multiple disciplines. The programme combines innovative educational approaches including virtual reality, simulation, online learning, face-to-face workshops, a virtual dementia experience, and nature-based learning delivered with Forestry England.

What We Did

A mixed-methods evaluation approach was used, mapping quantitative and qualitative data against Kirkpatrick's evaluation framework. Data sources included learner feedback, reflective outputs, interviews, and longitudinal follow-up discussions. Evaluation explored behavioural change, collaborative practice, leadership development, and application of learning within workplace settings.

Results / Learning

Participants reported increased confidence in systems thinking, collaborative practice, leadership, and holistic patient-centred care. Learners described applying programme learning to multidisciplinary working, service improvement activity, and navigating clinical complexity. The immersive and reflective nature of the programme was perceived as particularly valuable in promoting transformative learning.

A key learning point was the challenge of evaluating multifaceted educational programmes using traditional linear evaluation approaches. Early evaluation conducted within individual learning modality silos limited the ability to capture cumulative programme impact.

Sustainability / Next Steps

Future work is focused on embedding programme-level longitudinal evaluation strategies from programme inception to better capture behavioural, cultural, and systems-level change.

Key Take-Home Messages

Immersive multiprofessional generalist education can support workforce transformation, collaborative practice, and systems-based care. Evaluating complex educational programmes requires integrated, longitudinal approaches aligned to programme theory and real-world healthcare complexity.

Submission ID: 110

Title: A trust-wide resident doctor wellbeing initiative to procure and distribute Patagonia fleece jackets: a quality improvement report

Presented by: Ebrahim Luthfi Abousher, Core Trainee / ST1-ST3 Doctor; Amreen Mustafa, Foundation Year 1 Doctor; Midlands

Poster presentation section 3: 14:05 - 15:15 learning, leadership and inclusion

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working; Person centred practice; Social justice and health equity
Relevant enhance cross-cutting themes: Leadership; Wellbeing

Background

Junior doctor burnout represents a growing NHS workforce crisis. The GMC National Training Survey 2024 identified that 40% of doctors in training felt burned out to a high or very high degree. Against a backdrop of sustained real-terms pay erosion and post-industrial action disengagement, there is an urgent need for practical, trust-level wellbeing interventions that foster organisational belonging and recognition.

Aim

To design, procure, and deliver a trust-wide wellbeing initiative providing free Patagonia Better Sweater fleece jackets to all eligible resident doctors at Sandwell and West Birmingham NHS Trust (SWBH), funded by accumulated and previously unallocated cremation fee income.

Context

SWBH accommodates one of the largest resident doctor cohorts in the West Midlands. Following the opening of Midlands Metropolitan University Hospital (MMUH) in October 2024, resident doctors reported a consistently cold working environment with no control over the temperature. Concurrently, approximately £70,274 of cremation fee income had accumulated within the Doctors' Mess fund and was required to be spent before the financial year-end.

What we did

A democratic mandate survey was distributed (n=216; 95.8% in favour). A bespoke Google Forms preference survey capturing 83 colour and size combinations was deployed. Orders were placed via the Patagonia European Industry Program, securing a 40% bulk discount. A total of 453 jackets were procured at £35,256. Distribution was coordinated across four structured collection days in June 2025, supported by 23 volunteers. Uncollected jackets were reallocated via a secondary application process (86 applicants). A post-distribution feedback survey was completed by 84 respondents.

Results

98.8% of respondents felt more valued by their workplace. 98.8% reported a positive impact on morale and wellbeing. 100% would recommend similar initiatives. Mean unity and togetherness score was 4.44 out of 5. Qualitative themes included organisational recognition, logistical professionalism, collective identity, and desire for replication.

Take-home messages

Underutilised institutional funds represent a practical, budget-neutral resource for meaningful trust-level wellbeing initiatives. This model of having a democratic mandate, bulk procurement, volunteer-supported distribution, and formal outcome measurement, is transferable across NHS trusts and workforce groups. Ethics approval was not required; no patient data were used.

References

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Pathmanathan A, Snelling I. Exploring reasons behind UK doctors leaving medicine. BMJ Open. 2023;13(9):e068202

Submission ID: 111

Title: Improving Recognition and Continuity of Domiciliary NIV During Acute Hospital Admissions: A Quality Improvement project

Presented by: Lakshaajeni Thevapalan, Foundation Year 1 Doctor, East of England

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working; Person centred practice; Complex multimorbidity
Relevant enhance cross-cutting themes: Digital; Leadership

Patients established on domiciliary non-invasive ventilation (NIV) depend on continued respiratory support during hospital admissions. Failure to recognise and continue home NIV can lead to decompensation, prolonged admission, and adverse outcomes. This audit was prompted by a patient safety incident (QSAFE) involving a patient with chronic hypercapnic respiratory failure whose domiciliary NIV was not prescribed on admission. The patient subsequently deteriorated and died during transport home. The aim of this audit was to evaluate current practice in the documentation and continuation of domiciliary NIV during acute admissions at James Paget University Hospital.

A retrospective review of 137 patient records was undertaken, with 8 patients meeting inclusion criteria. The objectives were to determine how often domiciliary NIV was continued on admission, assess the timing of prescription, identify barriers contributing to delays, and evaluate the quality of documentation in order to develop interventions that improve continuity of care.

COPD was present in 87.5% of patients, with 62.5% having type 2 respiratory failure. NIV was initiated in 87.5% of cases, with 75% receiving NIV on the day of admission. However, documentation was poor: only 25% had NIV recorded in initial clerking, while 62.5% had no documentation at admission. In several cases, NIV requirements were only identified later during post-take ward rounds or by respiratory specialists. Delays occurred in 12.5% of patients and were due to equipment unavailability. Respiratory nurse specialist review occurred in 87.5% of cases, and by respiratory consultants in 75% cases.

This audit demonstrates that domiciliary NIV is usually commenced promptly once recognised, but early identification and documentation remain inconsistent. The QSAFE incident highlights the potentially serious consequences of missed domiciliary NIV. We have now added NIV prescriptions to EPMA and alerts to EHR. Further teaching will be provided on the importance of documenting domiciliary NIV at admission and discharge, and a re-audit will be undertaken to assess improvement.

Submission ID: 116

Title: Post-Stroke Depression QIP

Presented by: Kashaf Zaidi, Foundation Year 1 Doctor; Sulekha Ali, Foundation Year 2 Doctor; East of England

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Wellbeing

In our hyperacute stroke unit, patients from across the region are admitted for treatment. Following this life-changing event, many patients show signs of low mood. Many patients have suffered some form of depression following their stroke, which leads to increased morbidity and mortality (1). Without robust screening tools and procedures, patients who require help may go undetected, creating barriers to providing holistic care. Our quality improvement project is a prospective study identifying patients who may have developed post-stroke depression during their hospital admission. We analysed current practice in identifying patients with low mood and the support offered.

Our inclusion criteria were patients who had a diagnosis of an ischaemic or haemorrhagic stroke. Our therapy colleagues have conducted the SSNAP (Sentinel Stroke National Audit Programme) and SODS (Signs of Depression Scale) assessment questionnaire, which allowed us to identify our patient group.

We collected data by analysing clinical notes of all stroke patients currently admitted onto the ward to see if there was a documented mood screening tool (SSNAP and SODs score). Patients who met our inclusion criteria were given a PHQ-2 questionnaire when the duration of their admission exceeded two weeks or more, using translators when needed. The PHQ-2 asked them about signs of depression and low mood. Our intervention was to send a clinical psychology referral to the patient who were scoring high on the questionnaire with their consent.

Although this QIP is in its first cycle, the information has been very insightful. One early learning point is that our aphasic patients were unable to verbally communicate their answers to the PHQ-2 questionnaire. In the future, we can develop a more accessible screening tool that allows for both verbal and non-verbal communication. Furthermore, some patients did not have a documented mood screening initially, and therefore, their needs were not identified.

It is essential we treat the patient holistically by working collaboratively with our medical team, therapy team, psychologist and other healthcare professionals to deliver person-centred care and reduce the risk of multimorbidities.

References

Wang, X. et al. (2026) 'Modified jie-yu-he-huan capsule in post-stroke depression treatment: Insights from DIA proteomic and PRM validation', Drug Design, Development and Therapy, Volume 20, pp. 1–1. doi:10.2147/dddt.s565281.

Submission ID: 117

Title: Optimising resident doctor reviews on the postnatal ward: A Quality Improvement Project

Presented by: Manya Kumar, Foundation Year 2 Doctor; Hannah O'Connor, Foundation Year 2 Doctor; Midlands

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; System working; Population health
Relevant enhance cross-cutting themes: Wellbeing

Background

Resident doctors working in Obstetrics and Gynaecology routinely review patients in the postnatal ward independently. This can be challenging for doctors with limited or no prior obstetric experience given the complexity of these reviews.

Aim

Improve resident doctors' confidence in reviewing postnatal patients

Methods and Results

To explore this further, a survey was distributed to the incoming cohort of resident doctors (April–August rotation) to assess their level of training and confidence in managing common postnatal reviews and conditions. These include post–Caesarean section reviews (including iron supplementation prescribing), assessment of postnatal venous thromboembolism risk, prescribing thromboprophylaxis, and management of postnatal sepsis. Following this, we developed and distributed a digital handbook containing summaries of these common scenarios alongside relevant flowcharts and Trust guidelines.

To gather objective feedback from resident doctors regarding their perception of postnatal ward, they were asked to rate their confidence as ‘not confident’, ‘somewhat confident’ or ‘very confident’ in the pre-intervention survey. A follow-up survey has been distributed one month into the rotation. We have used the same scale to allow comparison. 2 new domains include assessing the quality and usefulness of the handbook, rated on a 1 to 5 scale (1 representing ‘very useful’) and a free-text space for suggestions. While the follow-up survey is still being completed, the feedback received so far has been positive. Based on the cumulative responses and suggestions, we plan to liaise with the Clinical Director to explore incorporating this into the induction. Alternatively, we can commence another cycle to further refine and improve the handbook.

Key learning points

The handbook is a simple low cost intervention which acts as a quick reference for busy resident doctors. Having this guide will not only improve their confidence but also streamline day-to-day clinical decision making. Additionally, a better understanding of postnatal care will help them facilitate shared decision making and deliver person centred care. This, in turn promotes timely patient management and improves patient flow, contributing to a sustainable use of healthcare resources. For the doctors, this may help promote a more structured day, improve their clinical confidence thereby boosting job satisfaction and wellbeing.

Submission ID: 118

Title: FIT For Frailty? A novel geriatric service delivering patient-centred care to elderly patients referred to the 2WW Lower GI Pathway

Presented by: David Xi, Foundation Year 1 Doctor; Shruti Darak, Foundation Year 1 Doctor; East of England

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Person centred practice; Complex multimorbidity
Relevant enhance cross-cutting themes: Transformative reflection; Leadership

Introduction

The prevalence and mortality rates of colorectal cancer are disproportionately greater in older patients (1). However, their expectations and suitability for invasive investigations or treatment tend to be underexplored in the current 2-week wait (2WW) pathway for suspected colorectal cancers in the UK (2-3). With an aging population in the UK, a holistic approach to colorectal cancer management is recommended.

Previously, the incorporation of first contact geriatric clinics in this pathway has shown to tailor treatment according to frailty and shared decision making (2-3). This retrospective audit will evaluate if a similar clinic at Broomfield Hospital shared similar successes.

Methods

This is a retrospective audit of the 2WW lower GI geriatric clinic, from February to October 2025, using GP referral forms and geriatric clinic letters on Lorenzo database. The main objectives discussed are the number and proportions of patients who received no investigations, CT colon and colonoscopies as the initial investigation, patient deaths and cancer diagnoses.

Results

A total of 629 (278 male, 351 female) referrals were analysed, with an average age of 84.60. Most patients (266, 42.29%) received CT colon as the initial investigation. There were 66 (10.49%) patients who received colonoscopies and 195 (31.00%) who received no initial investigations. The average Clinical Frailty Score (CFS) for patients receiving CT colon, colonoscopies, and no investigations as their initial investigation were 4.27, 3.47 and 5.51 respectively. 119 (18.92%) patients chose not to investigate due to personal wishes or advanced frailty. 71 (11.29%) patients with no investigations had recent reassuring tests or no red flag symptoms. There were 54 (8.59%) deaths and 37 (5.88%) cancer diagnoses (all cancers) at the time of audit. 23 (3.66%) patients had a colorectal cancer diagnosis.

Conclusion

This novel clinic service is effective in tailoring management of older patients referred to this pathway, with an acceptable cancer detection rate. The preferred initial investigation modality of CT colon has the additional benefit of capturing incidental non-colorectal cancers. The skills used to deliver this service are transferable to the many established clinics, both virtual and in community hospitals, for the future planned NHS neighbourhoods.

References

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Authors: Dr David Xi (FY1), Dr Shruti Darak (FY1), Dr Shaik (CF), Dr Can Hussein (CF), Dr Stevenson, Dr Suthahar

Supervisors: Dr Suthahar (consultant), Dr Stevenson (consultant)

Clinic consultants: Dr Suthahar (consultant), Dr Stevenson (consultant), Dr Ishaque (consultant), Dr Sweeting (consultant), Dr Ewins (consultant), Dr Orpin (consultant)

Submission ID: 119

Title: Strengthening Primary Care Engagement for People Seeking Asylum in Temporary Accommodation: A Quality Improvement Pilot Using a Thinking Space Approach

Presented by: Robert Adams, GP; Frauke Westgate, Community Engagement Care Coordinator; London

Short oral presentations session 2: 11:40 – 12:40 social justice, health equity and population health innovations

Affiliation to enhance: Currently in an enhance explore programme
Relevant enhance domains: Person centred practice; System working; Social justice and health equity
Relevant enhance cross-cutting themes: Transformative reflection; Leadership

Background / Problem

People seeking asylum in temporary hotel accommodation face significant barriers to primary care, including language barriers, digital exclusion, uncertainty about entitlements, and reliance on accommodation staff to navigate services (British Red Cross, 2023). In Woodberry Wetlands PCN, clinicians identified low uptake of New Patient Health Checks (NPHCs) and high DNA rates. This project explored how primary care, voluntary sector, local authority and accommodation partners could improve access, trust and equity.

Aims

To improve primary care access and engagement for people seeking asylum, including GP registration, NPHC uptake, trust-building, and links to wider support.

Context

The project centred on people seeking asylum, whose experiences shaped the intervention, working in collaboration with GPs, care coordinators, voluntary and community sector partners, local authority, hotel managers, North East London ICB and Thinking Space consultants.

What we did

The team used system mapping and reflective Thinking Space sessions to identify barriers and opportunities for change. A hotel drop-in supported GP registration, NPHC booking and digital health navigation. Learning informed a resident focus group exploring GP access, support needs, and ultimately co-creation of a “Welcome Pack for People Seeking Asylum”.

Measures / Evaluation

Measures included registration-to-first-appointment time, NPHC completion, attendance after booking, resident feedback and stakeholder learning.

Results / Learning

Baseline data showed 75% of registered patients at one surgery and 35% at another had not completed their NPHC. In the focus group, only 40% of residents knew about the NPHC. Residents identified barriers including language, online systems, immigration worries and same-day appointment access. All felt a welcome pack would help on arrival, with physical activity, mental health support and HC2 certificates emerging as priorities.

Sustainability / Next steps

Welcome packs have been shared with hotel managers across the PCN. Funding is being sought for culturally sensitive translation, with outcomes reviewed in September 2026. This model could then be scaled across the ICB and adapted for other inclusion health groups.

Key learning points / Take-home messages

System mapping identified actionable opportunities for change. Resident co-design and targeted multiprofessional collaboration provided richer insights than small datasets alone. The approach was low-cost, inclusive and transferable.

References

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Submission ID: 121

Title: Improving the Final Handover: A Multi-Stakeholder Quality Improvement Initiative to Improve Discharge Letter Safety, Quality, and Timeliness

Presented by: Panayiotis Stavrinou, Foundation Year 2 Doctor, Midlands

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Not affiliated
Relevant enhance domains: System working
Relevant enhance cross-cutting themes: Leadership; Digital

Authors: Stavrinou P. , Bednall R., Gunning E.

Background

Discharge letters are a critical communication tool between secondary and primary care, directly impacting patient safety and continuity of care. In our Trust, only 78.6% are completed within 24 hours, with persistent quality concerns including missing medication changes, unclear follow-up plans, and poor documentation of escalation decisions. These gaps are consistent across different care groups and introduce safety risks and inefficiencies throughout the care pathway. Discharge documentation also places a significant and poorly defined burden on junior doctors, who are the primary authors despite limited formal training and experience in the different specialties.

Aim

To improve the quality, and timeliness of discharge letters while reducing clinician burden and strengthening communication with GP, outpatient and coding teams.

What we did

A mixed-methods approach was undertaken, including semi-structured interviews with ward doctors and ANPs, and surveys of GPs(n=43) and consultants(n=69,>25 specialties). Thematic and root cause analyses identified system, process, and communication challenges, alongside absence of standardised guidance and training. Findings informed co-design of a standardised discharge letter template prioritising stakeholder needs and reducing non-essential content. The intervention was presented to executive leadership, pharmacy leads and an IT working group to ensure organisational alignment. A pilot is underway across three wards(medical, surgical, stroke).

Results

Stakeholders prioritised clear diagnosis, accurate medication changes with rationale, escalation status, and explicit GP actions. Redundant content included copied investigation reports and excessive clinical detail. Key system issues included fragmented electronic systems, lack of training, and absence of standardised quality metrics. The redesigned template was co-designed to address these challenges and align outputs with end-user needs.

Sustainability/Next steps

Iterative Plan–Do–Study–Act cycles are underway. Sustainability is supported through a planned targeted induction training for incoming resident doctors as part of Trust induction, alongside an agreed novel Trust-wide audit framework to consistently evaluate discharge letter quality. The IT team has agreed to embed template changes and decision-support prompts following finalisation of guidance, enabling organisation-wide scale-up.

Key learning points

Multiprofessional co-production, standardisation, and integration of targeted training and audit mechanisms are critical for sustainable improvement in discharge communication. High-impact areas included reducing non-essential narrative content, improving documentation of escalation/RESPECT plans, and minimising unnecessary copied investigation reports and blood tests. This work helped bridge the misalignment between stakeholder priorities and provides clearer guidance to support residents in producing confident, efficient, and safer discharge letters.

Submission ID: 124

Title: Perceived Sustainability of Severn Deanery Hospitals by Resident Doctors

Presented by: Sophie Hebden, Foundation Year 2 Doctor, South West

Poster presentation section 2: 11:40 – 12:40 clinical quality, safety and sustainability

Affiliation to enhance: Not affiliated
Relevant enhance domains: Environmental sustainability
Relevant enhance cross-cutting themes: wellbeing

Author(s)

Dr Sophie Hebden and Dr Clare van Hamel

Background

Hospitals are major contributors to global warming and climate change, with significant energy consumption, waste generation and material and water usage. It is therefore pertinent to assess their sustainability credentials. Resident Doctors comprise a cohort of ‘grassroot’ employees across hospital estates, providing useful insights into the status of their workplaces. Green initiatives not only offer environmental benefits but also economic benefits for hospitals themselves.

Methods

A cross-sectional ‘sustainability’ survey was emailed to all Foundation Doctors within the Severn Deanery, with further promotion on social media, to assess the perceived environmental friendliness (using a Likert scale 0-10) of each hospital. The survey focused on recycling facilities, water refillable sites, use of recycled paper and heating, with a ‘white space’ box for further comments.

Results

71 Resident Doctors completed the survey (of whom 89% were Foundation Year 1/2). Median environmental friendliness was 5/10 (IQR 4-7). Overall, 69% felt there were inadequate hospital recycling facilities, with poor proximity preventing 80% from recycling correctly and 41% throwing recyclable waste into general waste bins daily. This was most pronounced in the ward environments. Inadequate refillable water stations were reported by 56% with purchase of single-use plastic water bottles in just under a quarter (22.5%). Subjective overheating in hospitals was experienced by 39% daily and 44% noticed open windows with radiators on. Only 51% reported that all wards used recycled paper for patient lists.

ConclusionsOverall, the perceived environmental friendliness of Severn Deanery hospitals was low. Inadequate recycling facilities was a major issue, as was paucity of refillable water stations and overheating of the workplace. Implementing additional recycling facilities to improve hospital waste management, encouraging recycled paper use and ambient temperature control merit further consideration.

Submission ID: 125

Title: The ALiHN Model: A Community-Led Approach to Early Career Professional Development

Presented by: Yuva Ravindran, Core Trainee / ST1-ST3 Doctor, Midlands; Angela Misra, Higher Trainee Doctor, London

Poster presentation section 3: 14:05 - 15:15 learning, leadership and inclusion

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: System working
Relevant enhance cross-cutting themes: Leadership

Authors :

Yuva Ravindran[1], Angela Misra[2], Emily Audet[3], Katrina Obas[4], Jamie Smyth[5]

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Affiliations:

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Background

Value-based leadership is critical in today's rapidly evolving healthcare systems. Healthcare leadership disparities and limited representation of early career professionals (ECPs) remain inadequately addressed historic challenges. Traditional hierarchies continue to concentrate leadership opportunities among senior professionals, limiting ECP involvement in spaces where influence and succession planning are shaped.

The Aspiring Leaders in Healthcare Network (ALiHN) is a free-to-join, multi-professional global community, that aims to actively embed ECPs within leadership spaces, allowing them to contribute to change whilst developing leadership and improvement skills. We define ECP as a healthcare student or professional within five years of commencing their professional role.

Aim

To describe the ALiHN model of intentional ECP engagement within leadership spaces, including its contribution to leadership development, collaboration, and succession planning.

Methods

We showcase the ALiHN model, reflect upon and demonstrate the opportunities and early successes that this network has created for ECPs and healthcare leaders to successfully collaborate.

Emerging Themes and Conclusions

Over 2 years of development the ALiHN committee has worked with members and healthcare leaders to clearly define the network's mission, vision and purpose. We've formed collaborative spaces and identified aligning healthcare forums and organisations. Subsequent partnerships allow mutual benefit where ECP members access spaces where they can contribute, learn and develop, whilst organisations get fresh perspectives, energy and skills and identify potential for succession planning.

The network has helped shape national and international healthcare conferences, supported ECPs (including ENHANCE doctors) to deliver sessions at an international conference, partnered ECPs with mentors, supported ECPs to publish in a leadership blog series and collaborated with senior leaders from national and global healthcare organisations such as IHI, BMJ, AQUA and VMI.

Unlike other high-stakes sectors with structured leadership pipelines, healthcare leaders typically develop on the job. Mentoring remains luck-dependent, and leadership pathways are rarely integrated with clinical training. The ALiHN model positions ECPs as contributors of authentic leadership and reverse-mentoring perspectives rather than passive recipients of development. It is a scalable and replicable approach to embedding structured and impactful ECP leadership development within healthcare systems. Future work aims to undertake an impact assessment of ALiHN.

Submission ID: 126

Title: Using Community Health and Wellbeing Workers to Improve Uptake of Asthma Reviews for Children in Socio-economically Deprived areas: A Quality Improvement Project

Presented by: Daisy Blaksley, Foundation Year 2 Doctor; William Pickles, Foundation Year 2 Doctor; South West

Short oral presentations session 2: 11:40 – 12:40 social justice, health equity and population health innovations

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Social justice and health equity; System working
Relevant enhance cross-cutting themes: Wellbeing

Asthma is a chronic respiratory condition with worse outcomes in children from deprived areas. NICE recommends regular reviews to improve control and reduce exacerbations and hospital admissions; however, attendance is lower in deprived populations due to barriers including limited health literacy, digital exclusion, competing life stressors, and difficulty accessing services. Qualitative evidence highlights additional barriers to asthma care engagement, including weak patient / clinician partnership, organisational access difficulties, and psychosocial stressors affecting self-management and attendance at routine reviews (PMID: 28993623).

This QIP was undertaken at St Austell Healthcare, where novel Community Health and Wellbeing Workers (CHWWs) are non-medical, trusted community leaders embedded within high-deprivation postcodes. Acting as a bridge between primary care and local communities, CHWWs address social determinants of health through outreach, engagement, and facilitation service access. Early baseline work identified opportunities to improve asthma review uptake in children and young people living in areas of greatest deprivation.

The aim was to improve uptake of asthma reviews in children through a multiprofessional, system-based intervention aligned with the Enhance domains of Social Justice, System Working, and Wellbeing. An educational resource was developed to improve CHWW understanding of asthma reviews, followed by a focus group to co-produce strategies for CHWWs to support appointment booking, digital access and engagement with healthcare correspondence.

Formal outcome data are still emerging as asthma reviews are still ongoing; however, early findings are encouraging and suggest an increase in review uptake post intervention.

Initial outcomes indicate that embedding trusted community roles within primary care systems can improve engagement with preventive care by addressing non-clinical barriers not reached by traditional models. The project advances health equity and system working by shifting care from reactive, clinician-led delivery to proactive, community-integrated prevention. It also supports the Wellbeing theme by strengthening CHWW autonomy, competence, and sense of belonging, while improving multi-professional collaboration between CHWWs and general practice teams.

This was a single-site pilot dependent on existing infrastructure, limiting generalisability and scalability. Additionally, postcode-level selection may not fully capture individual deprivation. Future work should assess sustainability and determine whether improved review uptake translates into reductions in exacerbations and hospital admissions across broader populations.

Submission ID: 128

Title: The North Mid Enhance programme – development of live teaching sessions (3 cycles)

Presented by: Sana Mallick, Locally Employed Doctor (LED); Alice Man, Consultant; London

Poster presentation section 3: 14:05 - 15:15 learning, leadership and inclusion

Affiliation to enhance: Previous enhance fellow (any region)
Relevant enhance domains: Population health; System working; Person centred practice
Relevant enhance cross-cutting themes: Transformative reflection; Wellbeing

Dr Sana Mallick, Enhance Fellow at St George's Hospital

Dr Alice Man, Director of Medical Education, North Middlesex Hospital

Background

The NMH education team were approached by the London Foundation School to develop and pilot a programme of face-to-face teaching sessions for Enhance and to date, 3 cycles have been delivered, the first was to the August 2023 cohort.

Aim

• To provide a live teaching experience for the Enhance topics, showcase examples of the Enhance domains in clinical practice and allow discussions through interactive exercises.

• To support the FY doctors gaining the Enhance Enable certificate.

Context

The first two cycles were codesigned and delivered with the NHSE Associate Dean for Enhance, the Enhance Fellow and the Director of Medical Education at NMH (2023 and 2024 cohorts). The third cycle was led by the NMH DME, and codesigned and facilitated with a Haringey Public Health Consultant and the Enhance Fellow at St George's Hospital. The programme was attended by FY1s and FY2s jointly.

Method – What was done

The pilot cycle one (2023 cohort) consisted of six 1 to 2 hour sessions inserted into the existing weekly Foundation Teaching Programme. This included presentations on the principles of Enhance and a Learning Disability Consultant with case studies.

Cycles two and three (2024 and 2025 cohorts) were delivered as two half day sessions.

Cycle two (2024) included a learning disability patient lived experience and a psychiatry ST5 presenting a project on weaning antidepressants.

Cycle three (2025-2026), real-life examples included Public Health case studies, evolving medical specialties, planetary health, AI and a nutrition session delivered by an anaesthetic resident doctor and qualified personal trainer. There were multiple transformative reflection exercises including discussions and role play. The FY doctors were encouraged to use these for completing their REAL forms.

Measures and Evaluation

Feedback was collected but there was a poor response to online surveys.

In session verbal feedback and written feedback via emails provided qualitative narrative feedback that was meaningful and helpful.

Comments from the first cycle included relief at being ‘ungaslit’. There was a sense of a safe environment to discuss sensitive issues such as managing stress and burn out. However, one to two hours was not long enough to complete all the interactive exercises.

Cycle two (2024) comments included ‘enjoyable and informative’. ‘relevant topics’.

Cycle three (2025/26) feedback was again generally helpful. There was good engagement in discussions evidenced by the quality of reflections drawing on their own experiences.

Results and Learning

For each cycle of the NMH Enhance programme completed, the learning fed into the next cycle.

After cycle one, it was rescheduled to two half day sessions to allow more time for discussions and invited speakers.

Cycle two, Enhance was officially part of the FY curriculum and 43 FY doctors at NMH gained the Enhance Enable certificate after attending (90 FY1s and FY2s at NMH in total).

For cycle three, 84 FY doctors attended the whole programme. Data on completion of Enhance Enable is still in progress.

Sustainability and next steps

The NMH programme is locally led, although its set up had been supported by the NHSE Enhance Fellows and Associate Dean in the early stages. This support has been discontinued since March 2026 and it will continue to be delivered by the site education team and local clinicians. Plans have already been made for the next cycle August 2026/27.

Key learning points and Take-home messages

The NMH Enhance programme is a rewarding, enjoyable experience for FY doctors, bringing its domains and themes to life, with speakers ranging from resident doctors, consultants and patients. It draws on local real-life examples and experience making it more relevant and relatable.

Submission ID: 129

Title: Evaluating the Impact of Care Home Ward Rounds on Deprescribing, Advance Care Planning, and Unplanned Admissions: A Quality Improvement Project

Presented by: Ella Shepherd, Foundation Year 2 Doctor, East of England

Poster presentation section 1: 09:30 – 10:30 digital innovation and pathway redesign

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Person centred practice; Complex multimorbidity; System working
Relevant enhance cross-cutting themes: Leadership

Authors: 1 Dr Ella Shepherd, 2 Dr Navin Ghosh.

Background

Care home residents account for a large proportion of unplanned admissions, these can be distressing and potentially avoidable. A lack of clear advance care planning can lead to unnecessary, and even harmful, admissions. Polypharmacy is a prevalent issue and can lead to increased risk of admissions, falls, and harmful interactions.

Aim

This project aims to evaluate whether regular care home ward rounds, with a focus on deprescribing and advance care planning, can reduce unplanned hospital admissions.

Method and context

Our setting is 2 care homes with a total of 51 residents.

We collected baseline data by reviewing the number of unplanned admissions from care homes over the last 6 months. Care home ward rounds took place with the care home lead, general practitioner (GP), foundation year 2 doctor (FY2), and primary care network (PCN)

pharmacist. For each resident we conducted a holistic review and updated advance care plans, if necessary, with a discussion with the resident's family.

A repeat the ward round will be conducted in 2 months to review if any medications were re-prescribed, and the number of unplanned admissions.

Results

23% of residents had an unplanned admission in the past 6 months. So far, we were able to deprescribe for 71% of residents and update 34% of advance care plans. Care home staff found the ward round helpful, and families were grateful.

We await further data to see if our intervention has had an impact on unplanned admissions.

Unintended consequences

Many residents had not seen a GP since moving to a care home. This project promotes health equity by providing proactive, standardised care for vulnerable older adults who may have had barriers to accessing healthcare services.

Key learning points

Early data has shown a positive outcome from care home ward rounds. This is a sustainable intervention that will continue in the GP practice.

This project advances the Enhance themes of person-centred practice, complex multimorbidity, and system working by showing the impact of a multidisciplinary intervention aiming to adopt an individual, biopsychosocial approach when reviewing comorbid elderly patients.

The project was undertaken in accordance with local clinical governance.

Submission ID: 130

Title: Attitudes towards the use of Artificial Intelligence (AI) in Paediatric Healthcare, Insights from parents, carers, children and young people: A cross-sectional survey study

Presented by: Benjamin Morgan, Foundation Year 2 Doctor; Rachel Sullivan, Foundation Year 2 Doctor; Midlands

Poster presentation section 3: 14:05 - 15:15 learning, leadership and inclusion

Affiliation to enhance: Not affiliated
Relevant enhance domains: Person centred practice; Social justice and health equity
Relevant enhance cross-cutting themes: Digital

Authors: Dr Benjamin Morgan, Dr Rachel Sullivan

Background

There is little literature describing the views of parents, carers, children and young people (CYP) towards Artificial Intelligence (AI) in paediatric healthcare. Understanding these views are vital for developing strategies to support informed, shared decision-making and promote patient-centred care.

Aims

The aims were to identify current views and understanding of the use of AI in paediatric healthcare among parents, carers and CYP. A further aim was to assess how demographic factors influence perceptions of AI and to identify disparities in understanding and acceptance.

Methods

An observational, cross-sectional study was conducted using a study-specific ad hoc questionnaire. Parents and carers of CYP receiving care at Hereford County Hospital, a rural district general hospital, and CYP aged 11–17 years, voluntarily participated in the study between January and February 2026. Approval was obtained from the local QIP team. Paper questionnaires and an online version, accessible via QR code, were distributed with support from nursing staff. Quantitative data were analysed using ‘R’ statistical software and qualitative data using thematic analysis.

Results

52 completed questionnaires were included, out of 60 distributed. 21 CYP completed the questionnaire. Parental views were evenly divided, displaying similar levels of discomfort and comfort regarding AI, and an equal split in understanding of consent for AI.

Strong associations were demonstrated between parent/carer level of comfort with AI and level of understanding ($p< 0.001$). Participants from more deprived areas (lower index of multiple deprivation) were less comfortable with AI being used ($p= 0.015$). Higher understanding of AI was observed among participants in professional/highly skilled occupations ($p=0.029$). Concerns included potential errors with AI and the importance of human interaction. Efficiency and administrative support were viewed as benefits.

Conclusion

Identified concerns, including disparities among participants from more deprived areas and less skilled/ professional backgrounds, should be addressed to support the ethical implementation and equitable access to AI in paediatric healthcare. Families and CYP should be educated about the implementation and use of AI, supporting informed consent practices. Insights learned will enable a wide range of health care professionals to implement AI tools

confidently and responsibly, enhancing trust and optimising health outcomes across paediatric services.

Submission ID: 131

Title: Radiology reports and patient understanding: a narrative review of plain-language communication, health literacy and implications for patient-centred care

Presented by: Cameron Ashraf, Foundation Year 1 Doctor, North West

Poster presentation section 3: 14:05 - 15:15 learning, leadership and inclusion

Affiliation to enhance: Interested in taking part in the enhance programme (enable or explore pathways)
Relevant enhance domains: Person centred practice; Social justice and health equity
Relevant enhance cross-cutting themes: Digital

Authors: Dr Cameron Ashraf, Dr Hussain Al-Hilali

Background

Radiology reports are the predominant output of diagnostic imaging, yet they are written for clinical audiences and commonly contain technical terminology that many patients struggle to interpret. Since the 2023 NHS mandate allowing patients to access their hospital records via the NHS app, patients increasingly read their own imaging reports directly often before clinician discussion. An observational study demonstrated that low health literacy affects ~43% of working age adults in England, disproportionately affecting those of lower socioeconomic backgrounds, older patients or those where English may be second language (Rowlands et al., 2015). Low report comprehension often causes unnecessary anxiety about results and sometimes erosion of trust in clinical communication.

Methods

A narrative review was performed using available evidence from PubMed, NHS England and the Royal College of Radiologists. Studies were included where they assessed patient comprehension of radiology reports, evaluated interventions improving accessibility or explored workforce awareness of communication barriers.

Results

Evidence collated demonstrates a consistent and meaningful comprehension gap. A 2026 Lancet systematic review and meta-analysis of 38 studies showed lay people measured LLM-simplified radiology reports as 87% more understandable than original radiologist reports and clinicians rated them highly for accuracy in tandem (Alabed et al., 2026). A recent US study

found that AI-generated plain language reports improved comprehension accuracy by 10% compared to original reports (Chen et al., 2025). Improvements were most profound in adults over 44 without higher education. The Lancet study also noted 1 in 100 LLM-simplified reports contained clinically significant errors potentially altering interpretation and potentially reducing health anxiety or trust (Alabed et al., 2026). This highlights that while the evidence base for this technology is well founded, the methodology of implementation is currently immature.

Conclusions/Implications

Accessible radiology communications is both a patient safety and health equity issue. This is addressed by embedding plain-language digital technologies within radiology workflows coupled with multiprofessional education that allows clinicians, nurses and patient-facing staff to understand this communication gap. With patients now able to access their records easier than ever, this review highlights the need to address workforce education and a scalable, evidence-based solution to address these inequities.

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