To create a trainee centered medical induction at Velindre Cancer Centre (VCC)

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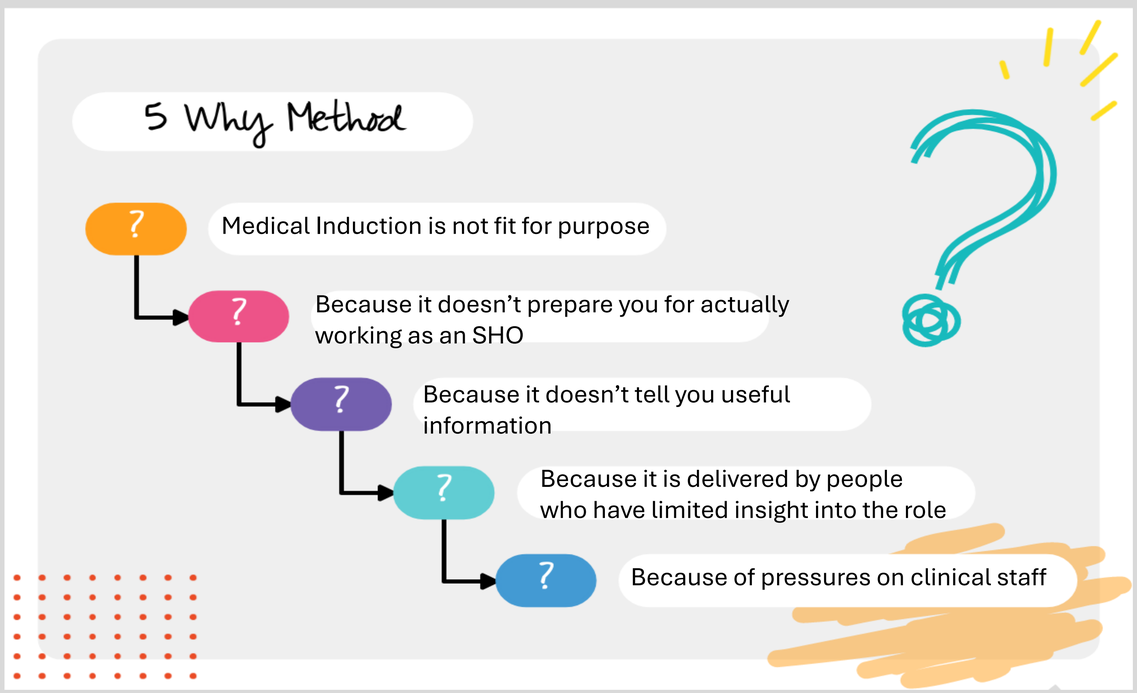
The problem

Formal feedback was collected from SHOs working in the role which found 83% felt that information given during their induction was 'not really' useful and it 'did not' prepare them well to start the job, and 100% felt the current induction needed to change.

The common theme in the written feedback was to include more clinical information relevant to the role of an SHO, delivered by someone who fully understands the role and practical information about working as an SHO at Velindre.

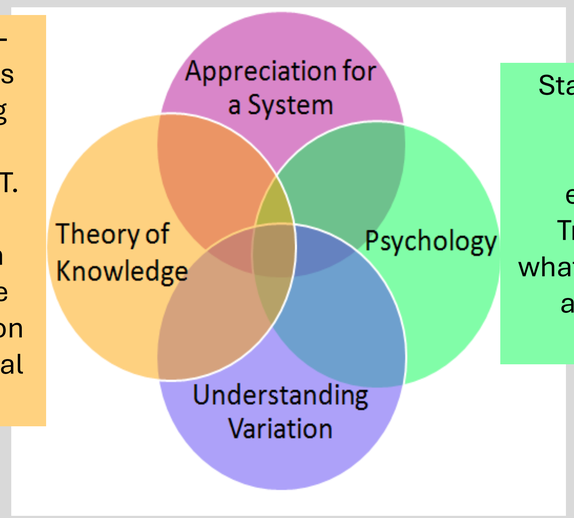
Understanding the problem



SOPK

At 6 points throughout the year resident doctors rotate into different specialties. They may have come from a different hospital, health board or even country. All Doctors will have immediate responsibility in managing acutely unwell Oncology patients and complex side effects from Oncology treatments.

These doctors are non-specialty junior doctors from a range of training programs including foundation, GP and IMT. Most will have no post graduate experience in Oncology and will have last had any teaching on this specialty in medical school.



Starting a job in a new specialty in a new hospital can be extremely daunting. Trying to understand what is expected of you and where to ask for help is important.

Each cohort of junior doctors that rotate through VCC will have different previous experience and knowledge of Oncology.

Project aim

We aimed to improve 'usefulness' of the medical induction at VCC from 47% to >90% over 1 year.

We will be measuring the effectiveness of the medical induction by asking for feedback via a series of questionnaires to all who attend the medical induction. These questionnaires will be in the form of an online survey looking at how useful each individual session is using the score outlined below

- Extremely useful – 10
- Very useful – 8
- Somewhat useful – 6
- Not so useful – 4
- Not at all useful – 2

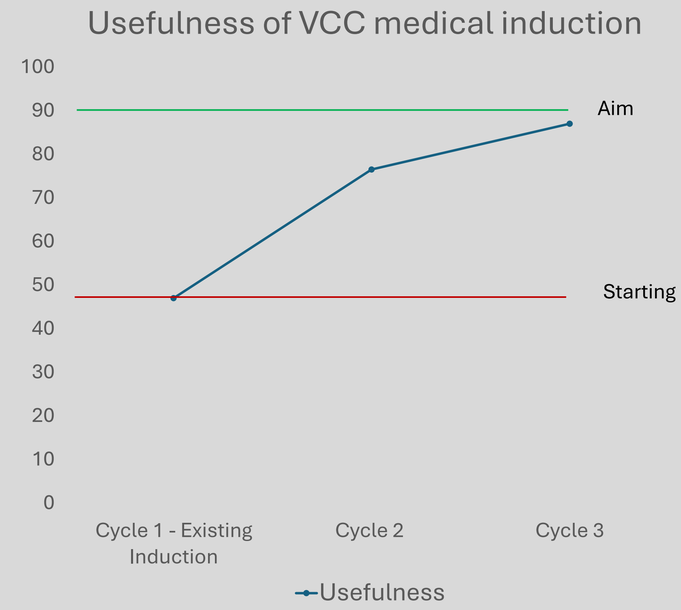
% 'usefulness' based on the above scoring system using the mean figure.

Process measure - Each individual session will be rated on how 'useful' the content was, as well as the length of time in order to help guide further changes. This will be in the form of an online survey at the end of each day of induction, asking all the people who were present at the induction that day.

Balancing measure – Financial impact on clinical cover for the Induction day. Previously SHOs have been allowed 1.5 days for induction, however not all were able to attend as some were pulled to cover the clinical areas despite not having any induction. The financial impact of covering the clinical areas with locums is significant, however the overall positive impact on patient safety and SHO experience of a thorough and effective induction is invaluable and therefore the increase financial input required was deemed to be worth it.

Results

We aimed to improve 'usefulness' of the medical induction at VCC from 47% to >90% over 1 year.



Cycle 2

Cycle 2 – Main focus/test of change – content/presenter

Initial feedback was collected at the time, in order to help us to improve for the next cycle. An additional feedback survey was sent out 2 weeks later – unfortunately, there were no responses to this. This highlighted the challenges of collecting data without the group in front of you and stressed the importance of collecting feedback at the time.

Results:

IT issues at every session led to sessions starting late/running over which in turn meant missed breaks and some sessions being cut short.
- For future sessions we will aim to have a shared folder so that each presenter can save their powerpoint to this ahead of the day which will save time of each person having to sign in and computers having to update etc.
- We will also try to have more breaks/contingency time to allow for sessions running over in order to minimize the effect on the rest of the day.

Only one session was delivered via **teams** and this caused a lot of IT issues
- For future inductions we will try to have all sessions presented in person or recordings

Moving rooms was challenging and often time hadn't been built into the timetable for this which led to sessions running late.
- For future sessions we will try to book one room for the whole day. We know the dates of rotations far in advance so can get the room booked ahead of time to avoid room clashes.

Recordings – in order to work towards making the induction future proof and less demanding on clinicians to deliver – some sessions were recorded and will be played to this group of doctors to gather feedback if this is a negative or positive change.

Feedback from other healthcare professionals – Certain topics weren't covered in enough detail such as pharmacy and so they were added and given a full session.

Adapt

Cycle 3

Cycle 3 – Main focus/test of change – Logistical issues (rooms, timings, IT)

3 of the sessions were given as recordings and these still gained good feedback which suggests that this is not an inferior option, although this could be a further project looking at this specifically.

"Best Induction I have ever had"

"Excellent induction. Thank you so much for organising"

"All very useful and set us up well for our rotation"

SWOT analysis

Take home messages

- Importance of involving SHOs to ensure the effective communication of the SHO role to the next group of doctors.
- Although the content is Junior Doctor and other healthcare professional led, it is necessary to have senior consultant input to allow for clinical cover to ensure all juniors can attend.
- Continued sustainability of the project relies on medical workforce and consultants continued input to identify appropriate presenters and book appropriate rooms in advance.