Improving GIM training and trainee-led service change

Authors: Melanie Nana, Helen Lane and Ruth Alcolado

Aims

To reconfigure medical inpatient care in a district general hospital, with the aim of improving general internal medicine (GIM) training and ultimately patient care.

Methods

In October 2015, we introduced a new medical model. It included:

- Expansion of acute and ambulatory services,with a fully staffed ambulatory emergency care unit (AECU) and acute medical team with daily consultant-led ward rounds of short-stay inpatients.
- A frailty service supported by a joint emergency therapy team, allowing rapid access to therapists and interim packages of care, facilitating early discharge.
- A general internal medicine (GIM) team, in line with the Royal College of Physicians' vision of a 'generalist' approach to complex comorbidity.

Junior doctors became 'ward-based doctors' as opposed to 'team-based', allowing cross-cover between different medical specialties including GIM. This aimed to provide broader-based training and improve continuity of care. Rotas were designed with trainee input to allow prolonged periods on each ward, enabling good relationships to be built within multidisciplinary teams.

All doctors appreciated that developing this model would require significant change and monitoring, but engaged in a culture of taking shared responsibility to lead change by agreeing to the reconfiguration, to improve patient care. Following implementation, oral feedback was collected at weekly meetings and through questionnaires.

Results

Successful development of AECU was seen, which now sees >25% of patients who would traditionally have been assessed on the medical intake. The GIM team integrated well, but suffered due to lack of a specific middle grade, as there are no specialist trainees in GIM alone. Opportunities to support this team could include rotation of specialty trainees dual-accrediting in GIM, allowing specific GIM training beyond the acute medical intake.

The trainees developed questionnaires focused on General Medical Council survey domains. These were completed by 20 junior doctors at each stage of restructure. They highlighted dissatisfaction with covering multiple specialties, as it was perceived to disrupt the team structure and 'apprenticeship model' of training. Therefore, trainees led further redesign to provide a stronger team structure within the model. This received favourable feedback, which shows that work intensity and equity, continuity of care, overall experience, GIM experience, team morale and perception of patient safety have improved since introduction of the model.

Conclusions

The project achieved its objectives. Junior doctors report that the new model has improved their training and that they have also gained leadership skills, feeling empowered to contribute positively to ongoing development and improvement in clinic practice. ■

Conflict of interest statement

We have no conflicts of interest to declare.

Authors: Royal Glamorgan Hospital, Llantrisant, UK