

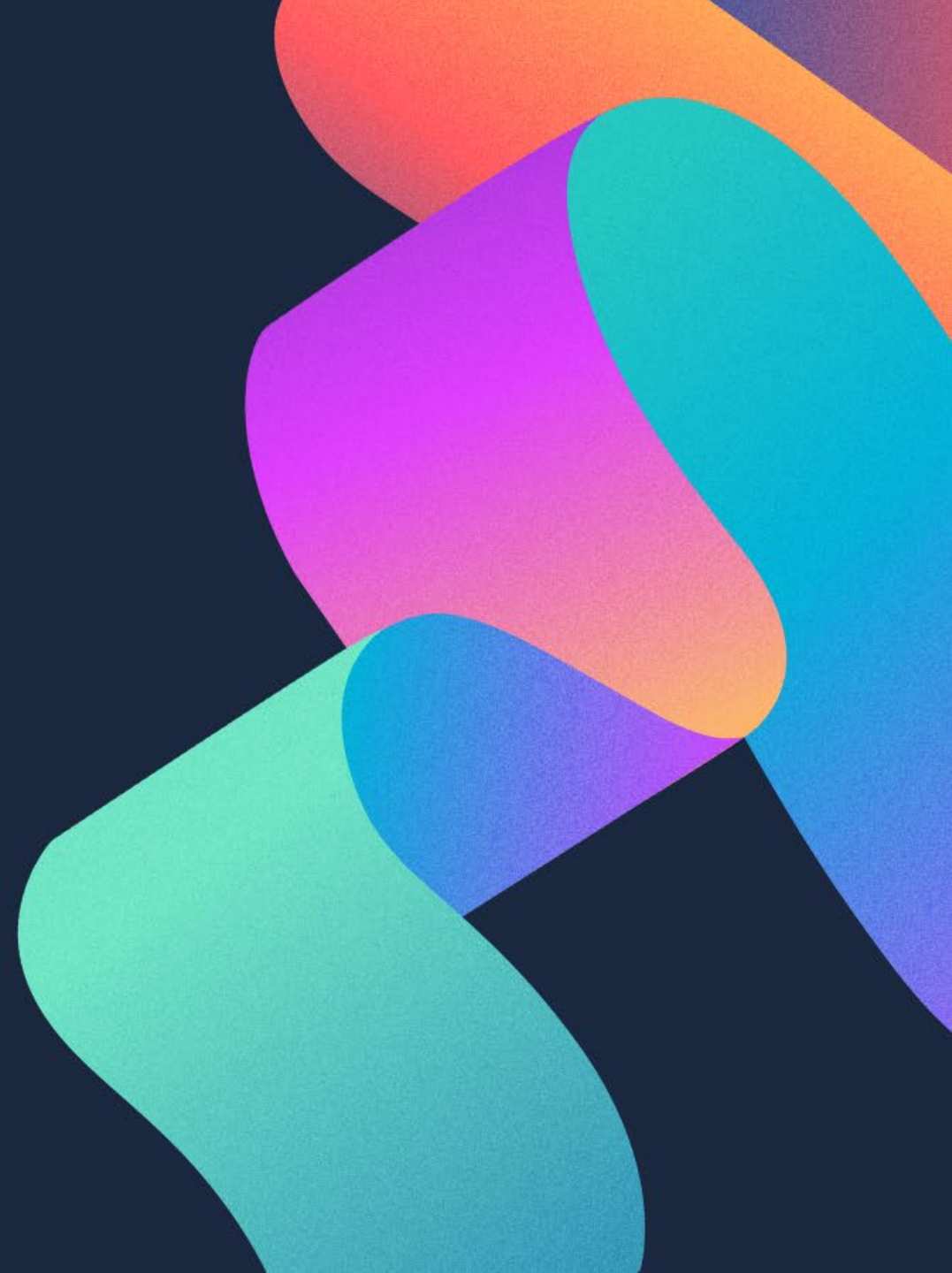


Royal College
of Physicians

Health services and sustainability, policy and workforce development

November 2025

rcpconferences.co.uk/med-plus-2025



NT-proBNP Clinic Audit

Safiyah Burhani and Pavandeep Toor

Introduction

NICE Guideline CG106 (1) makes recommendations for the timely assessment of patients with raised NT-Pro BNP levels as follows:

- NT-pro-BNP > 2000 ng/L, refer for specialist assessment and echocardiography within 2 weeks.
- NT-pro-BNP level between 400–2000 ng/L , refer for specialist assessment and echocardiography within 6 weeks.

The heart failure diagnostic clinic (HFDC) at Barking, Havering and Redbridge University Hospitals NHS trust is designed as a service providing investigation and clinical review of patients referred with raised NT-pro-BNP and suspected heart failure. We audited the HFDC at BHRUT to assess compliance with NICE guidelines and to identify areas for service improvement. The aims of the audit were:

- To analyse current referral and triage processes that lead to review in clinic.
- To assess whether patients with elevated BNP were reviewed in accordance with timeframes published in the NICE guidelines
- To evaluate the proportion of patients not identified as having heart failure who subsequently went on to be diagnosed with HF later.

Materials and Methods

We audited all patients seen in the HF diagnostic clinic in 2023.

The data was collected from GP referrals, clinic letters, HF team database, echocardiogram reports and blood tests.

Analysis of the data was performed in excel.

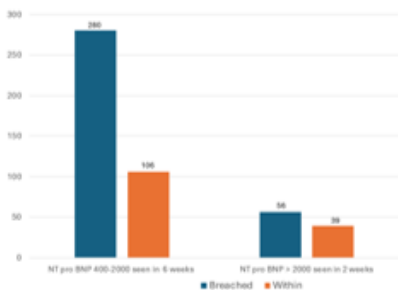
Results

Out of 481 patients included in the audit, a total of 116 (24%) were diagnosed with HF. Of these :

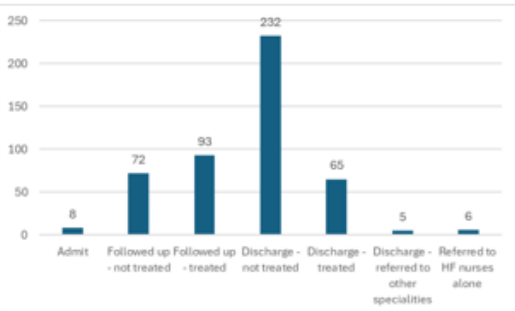


Did we meet the timeframes published by NICE guidelines ?

In the low-risk group 106 of 386 (27%) patients were seen within 6 weeks. In the high risk group 39 of 95 (41%) patients were seen within 2 weeks (Figure 2).



Outcomes of NT pro BNP clinic



232 patients (48%) were discharged with no treatment given (Figure 3)

Of the 365 patients who were not initially diagnosed with HF, 27 (7%) had the diagnosis of HF made at a later stage.

Discussion

Based on these results, the current pathway results in a high proportion of patients without heart failure being seen in the clinic and discharged with no treatment. With alternative reasons for the elevated NT pro-BNP levels eg age and atrial fibrillation. In a resource limited system this can have a negative impact on the delivery of a high quality, effective and efficient clinical service. Potential ways to improve the pathway include:

- Improved education/ training of referrers.
- Stricter referral/triage processes
- The use of alternative NT-pro BNP ranges based on alternative adjusted cut-offs eg age
- Strategic expansion of the workforce delivering the HF diagnostic clinic to include HF specialist nurses or registrars

Conclusion

The low proportion of patients diagnosed with heart failure, combined with the lack of timely review resulting from high demand suggest that the current pathway for HF diagnosis has room for improvement. Changes to the pathway may result in a higher proportion of HF identified, and improvements in timeliness of review in clinic to meet the guidelines recommended.

References

1. <https://www.nice.org.uk/guidance/ng106>
2. Bayes-Genis A, Docherty KF and Petrie MC et al. Practical algorithms for early diagnosis of heart failure and heart stress using NT-proBNP: A clinical consensus statement from the Heart Failure Association of the ESC. Eur J Heart Fail. 2023 Nov;25(11):1891-1898. doi:10.1002/ejhf.3036. Epub 2023 Sep 26. PMID: 37712339

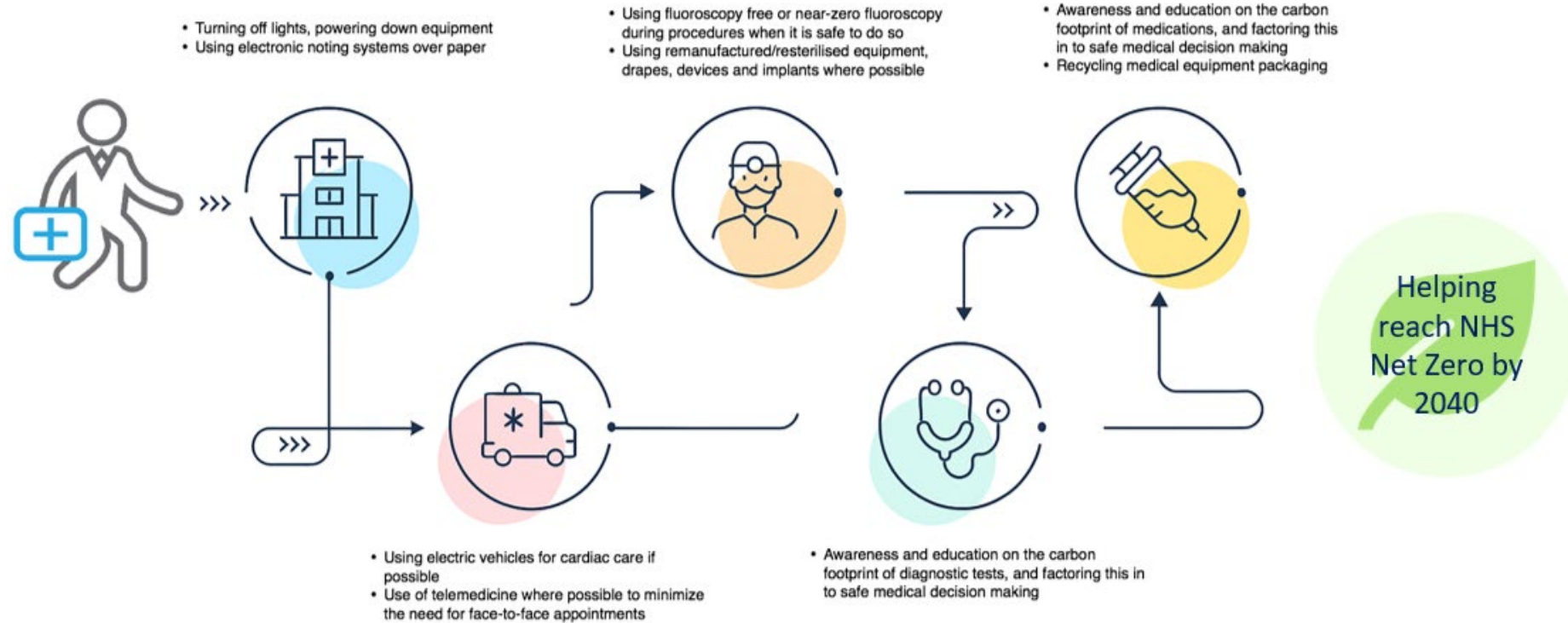
A Greener Pulse for Cardiology: Sustainability and Clinical Care in the NHS

Cardiology Department, St Thomas' Hospital

Akansha Sethi & Jaspal Singh Gill



Guy's and St Thomas'
NHS Foundation Trust



Sustainable practice is the responsibility of all healthcare workers

Sustainable changes help:

- Economise health systems
- Improve patient care
- Help reach environmental targets

Balancing sustainability with patient care is a key consideration

Promoting low carbon and recyclable options via NHS supply chains at national level will aid uptake

Understanding the “Why”- Job Satisfaction and Retention among Junior Hospital-Based Physicians in the UK: An Integrative Literature Review

Dr. Kennisha Powell MBBS(Hons.), MRCP, MBA - Edinburgh Napier University; NHS Northwest Anglia FT

Introduction

- The NHS faces a **staff retention crisis**, losing ~5% of doctors from the GMC register annually.
- Junior doctors are increasingly opting out of training; only **37.7% of FY2 doctors** continued into run-through programmes in 2018 (vs. ~70% in 2011).
- Burnout, low morale, and lack of work-life balance are major drivers of attrition.
- With the recent industrial actions taken from 2023-2025 it is of paramount importance to identify the root cause of dissatisfaction.

Aim/Objective

- To identify factors influencing job satisfaction and retention among UK junior doctors to inform NHS workforce strategies.

Methodology

- **Design:** Integrative literature review.
- **Data sources:** EBSCOhost and PubMed (MEDLINE, CINAHL, APA PsycArticles, Psychology & Behavioural Sciences).
- **Inclusion:** 12 Primary UK-based studies on Junior doctors.
- **Analysis:** Thematic content analysis using NVivo 12.
- **Process:** Identified factors → Coded into overarching themes

Results

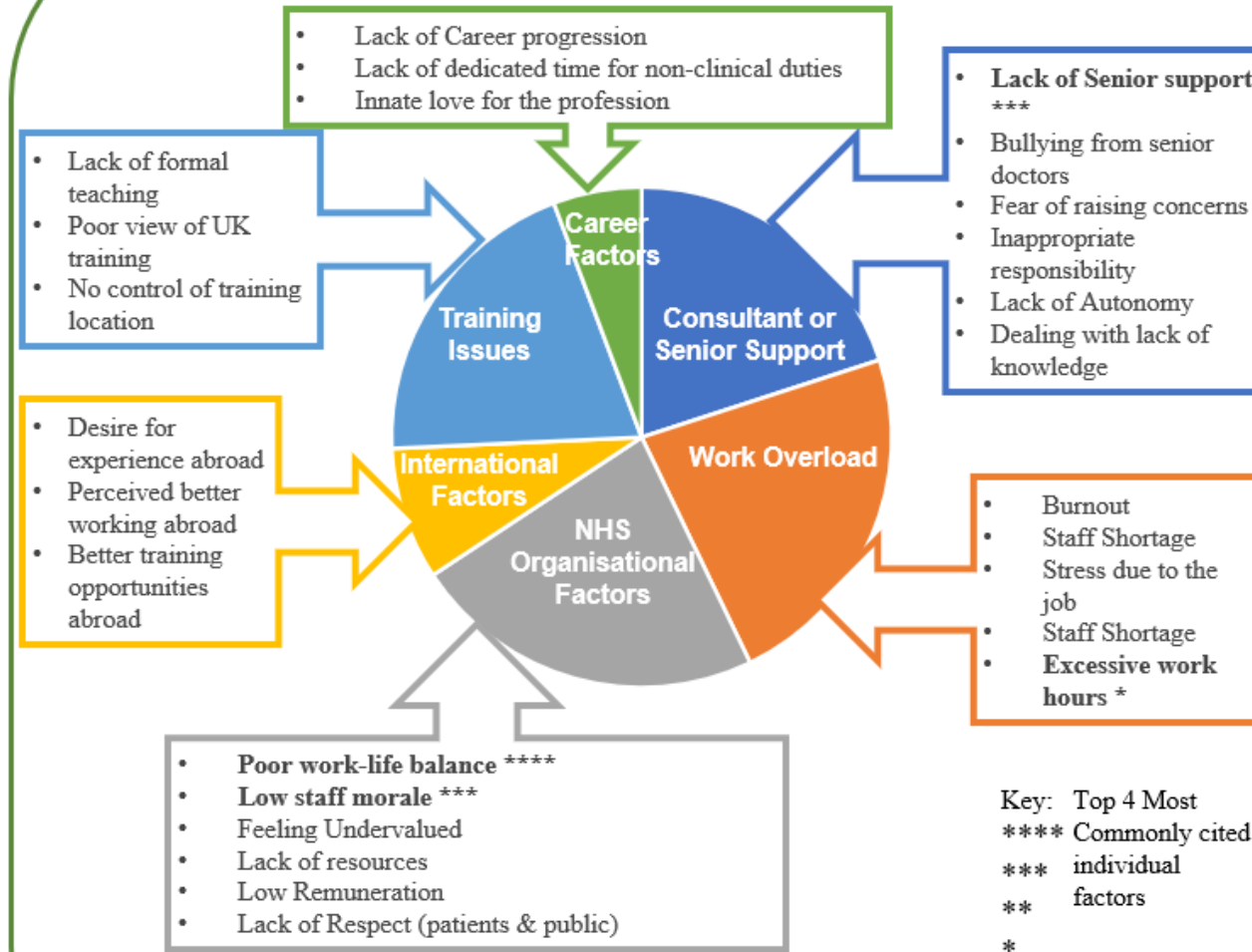


Figure 1: Factors influencing Job Satisfaction and retention among junior doctors in the UK

Conclusions

- Factors which influence Job satisfaction and retention are **multifactorial and inter-related**.
- **Poor Work-life balance** was the single most important contributor to dissatisfaction.
- Variations in responses suggest that satisfaction and retention strategies should be individualised to a doctors' circumstances.
- Addressing the why is the key to solving this complex, evolving problem

Implications in Practice

- **Workforce sustainability among doctors requires urgent reform.**
- **Long-term strategies and Short-term solutions** are required to tackle this complex issue
- Improve staffing levels and scheduling
- Strengthen mentorship and consultant support
- Protect training time and career development
- Foster a culture of respect and psychological safety

Scope for Future Research

- Primary data was relatively under-represented in the literature.
- This study serves as a baseline which could encourage collection of more recent, primary data on a National level >> Larger sample size >> More powerful study
- Demographic-specific factors (age, gender, specialty etc.)

A Grass Roots Approach To Rebuilding The Medical On-call Rota Following The Move Into The Midland Metropolitan University Hospital

Dr Zachary Pierrepont IMT3, West Midlands

Introduction

The Midland Metropolitan University Hospital (MMUH) is one of the largest acute hospitals to open in recent years. Following the merger of two acute sites, service pressures were anticipated, prompting the creation of a bespoke medical on-call rota to ensure safe coverage. This rota was informed by previous acute medical placement block experience within the trust [1]

Objective

To evaluate the bespoke MMUH medical on-call rota using a grass-roots, bottom-up approach that empowered Resident Doctors to make positive changes. The aim was to gather authentic feedback on wellbeing, workload, and educational value, and to collaboratively implement improvements based on lived experience.

Method

A mixed-methods survey assessed workload and wellbeing across shifts among Resident Doctors (FY1, SHO, and Registrar). Thematic analysis of feedback informed a co-design process with Resident Doctors, Consultants, and Rota Coordinators. A new rota was developed from this feedback and later evaluated by a Resident Doctor focus group.



Figure 1. A word cloud summarising the qualitative feedback from the review of the original medical on-call rota.

References

Buka R, Best D, Clare S. Rota changes in acute and general internal medicine: delivering improved patient care and junior doctor training at the front and back door – acute medical unit placement blocks the way forward for Midland Met! Future Healthcare Journal. 2019 Mar;6(Suppl 1):42.

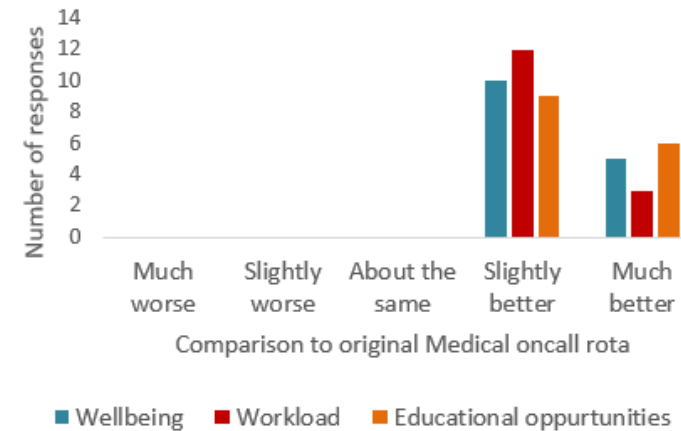


Figure 2. A bar chart summarising feedback comparing the new versus old medical on-call rota, assessing workload, wellbeing, and educational opportunities

Results

Survey responses of the original rota were collected from 71 Resident Doctors, representing 70% of those on the medical on-call rota. Over 60% reported negative wellbeing and unmanageable shifts. After implementing changes based on this feedback, the new rota was presented to a focus group of 15 Resident Doctors and received unanimous approval for improvements in wellbeing, workload, and training.

Conclusion

This project shows the powerful impact an on-call rota can have on Resident Doctor wellbeing. Empowering doctors to shape their own rota fosters ownership, drives sustainable workforce change, and inspires positive reform. Whilst the rota is newly introduced, continued feedback will be key to shaping lasting improvements.

Beyond Resilience & Wellbeing

Evaluation of a one-day flourishing-focused workshop for healthcare professionals

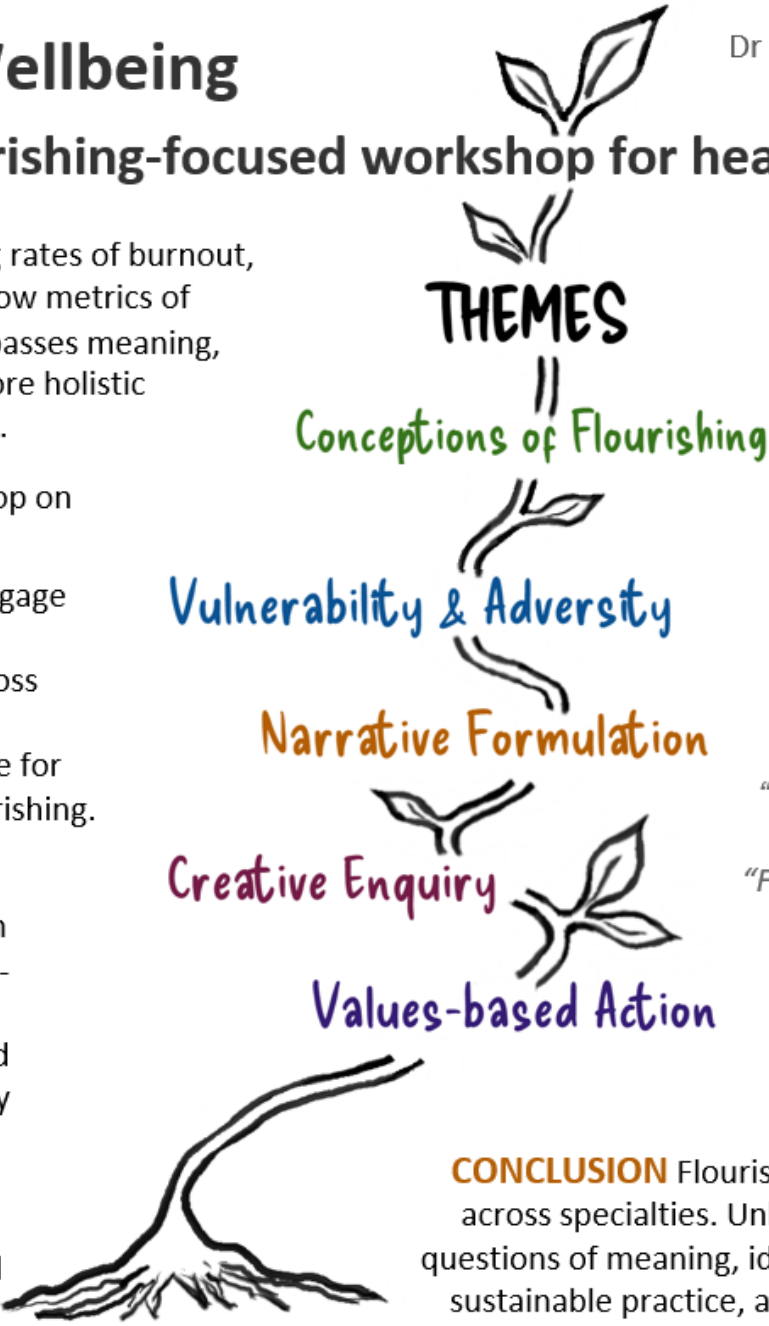
Dr Jeyapragash Jeyapala London North West University Hospital NHS Trust, NHS England
Dr Rupal Shah Professional Development Team London NHS England

INTRODUCTION Interventions to tackle rising rates of burnout, moral injury, and attrition¹ often focus on narrow metrics of resilience and wellbeing²⁻⁴. Flourishing encompasses meaning, values, vulnerability, and growth, offering a more holistic framework for approaching these challenges⁵⁻⁸.

AIMS To design and deliver a one-day workshop on flourishing for healthcare professionals that:

- Moves beyond resilience and self-care to engage with meaning, values, and identity.
- Is applicable to healthcare professionals across levels of training and specialties.
- Creates a safe, reflective, collaborative space for discussion of professional and personal flourishing.

MATERIALS & METHODS Four in-person Flourishing workshops were delivered between March 2024–2025. They were offered as stand-alone days or as part of a wider four-day programme on Generalism. Attendees included individuals of all levels of seniority and a variety of allied healthcare professionals. Responses were predominantly from resident doctors. Themes were drawn from written feedback (n=40) to identify perceived impact, utility, and suggestions for improvement.



RESULTS & DISCUSSION All participants would recommend the workshop to colleagues with unanimous positive responses.

RELEVANCE & APPLICABILITY Participants valued the importance of protected space to explore these ideas, and the chance to “reframe” challenges, recognise the role of vulnerability, and reconnect with personal and professional values.

LEARNING METHODS Small-group discussions, narrative exercises, and creative tasks (e.g. story exploration through art) were described as “inspiring,” “memorable,” “engaging,” and “empowering.” Incorporating philosophy and creativity into training was noted to deepened reflection and promoted openness.

IMPACT Attendees reported personal and professional growth:
“Opens your eyes into how change can be made, how to look forward to a future in medicine and that hope is out there for the profession”
“Fantastic, really well structured... it should be compulsory for all clinicians.”
“This is the best workshop that I have ever attended,”
“Reframed my whole career.”

Suggestions for improvement included more time for discussion, use of case examples, and further engagement with consultants, managers, and allied health professionals to facilitate culture shift.

CONCLUSION Flourishing-based training is novel and highly valued by healthcare professionals across specialties. Unlike wellbeing- or resilience-focused interventions, it engages with deeper questions of meaning, identity, and systemic context. This offers a timely reflective framework for sustainable practice, and personal and professional transformation, highlighting the importance of values-based action in the face of adversity.

REFERENCES 1. Cohen N, Meyer I. Trends in work-life balance, burnout and stress across ten years of National Health Service staff surveys in England: a longitudinal retrospective study. *PLoS One* 2023;18(4):e0294300. 2. Montgomery A, Leardi G. Creating healthy workplaces in healthcare: are we delaying progress by focusing on what we can do rather than what we should do? *Front Public Health* 2023;11:1155059. 3. Traynor M. Resilience as a mid-level theory of human development: a critical evaluation. *J Adv Nurs* 2019;74(8):1394-1401. 4. Robertson HD, Elliott MA, Barton C, et al. Resilience of primary healthcare professionals: a systematic review. *BJGP* 2016;66(647):e425-e433. 5. Paterson S, Edgar A. Flourishing in health care. *Health Care Anal* 2016;24(2):101-104. 6. Paelewa N, Paine S-J, Sinclair S, et al. Working in value-dissonant environments inhibits clinicians' ability to provide compassion and reduces well-being: a cross-sectional study. *J Intern Med* 2023;293(6):704-723. 7. Delgado J, de Groot J, McCaffrey G, et al. Towards collective moral resilience: the potential of communities of practice during the COVID-19 pandemic and beyond. *J Med Ethics* 2021;47(6):374-382. 8. Young L, Sengulhun D. Creative enquiry and the clinical encounter. *BJGP* 2020;70(880):26-27.

Optimising the Use of Repeat MRI Spine in Patients with Known or Suspected Axial Spondyloarthritis

Ishan Sen¹, James Kimpton²

¹Great Western Hospital, ²Royal United Hospital Bath

BACKGROUND

The role of inflammatory protocol magnetic resonance imaging (MRI) of the spine to aid the diagnosis of axial spondyloarthritis (axSpA) is well established.¹ However, the clinical value and optimal timing of repeat MRI scans remain uncertain, both for diagnostic clarity in individuals with risk factors and clinical suspicion for axSpA but negative initial imaging, and for guiding treatment escalation decisions in those with established axSpA.²⁻³

From a healthcare service perspective, our organisation has seen a 39% increase in MRI inflammatory spine requests between 2022 and 2025. This has contributed to system-wide radiology capacity pressures, potentially aggravating MRI waiting times. Identifying opportunities to rationalise the use of repeat imaging could mitigate these pressures.

AIMS

The aims were to evaluate the utility of repeat MRI inflammatory spine scans in patients with known or suspected axSpA, and to assess their impact on clinical management by reviewing clinic letters before and after MRI requests.

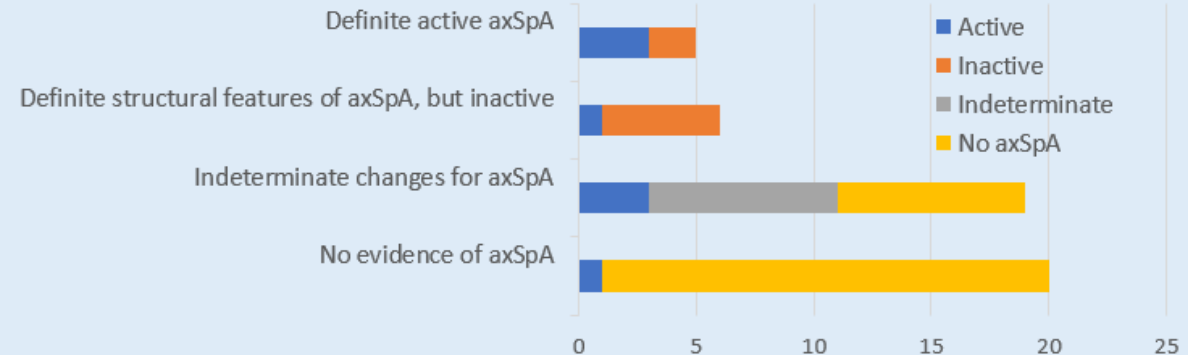
METHODS

A retrospective review was performed of patients undergoing ≥ 2 MRI inflammatory spine scans at a UK national specialist centre between January 2022 and February 2025. Data collected included demographics, clinical features (HLA B27 status, extra-musculoskeletal manifestations), imaging results, reasons for repeat scan, and clinical outcomes. Patients were stratified into the following categories, based on the findings of their initial and repeat imaging:

- Definite active axSpA
- Definite structural features of axSpA, but inactive
- Indeterminate changes for axSpA
- No evidence of axSpA

RESULTS

50 patients (median age 36 years, 76% female) were included; 54% were HLA-B27 negative and 32% had EMMs. The median interval between scans was 499.5 days.



Notably, none of the patients with negative initial imaging, HLA-B27 negativity, and no EMMs developed new axSpA changes on repeat MRI and 50% of them were discharged.

CONCLUSION

Repeat MRI spines appeared to have limited value in patients with negative initial MRI, HLA-B27 negativity, and no EMMs, none of whom developed new axSpA changes on repeat scans. These findings support consideration of earlier clinical discharge in this subgroup without repeat imaging.

Further prospective studies would be helpful to validate these findings and refine imaging pathways in axSpA.

References:

1. Ramiro S, Nikiphorou E, Sepriano A, et al. ASAS-EULAR recommendations for the management of axial spondyloarthritis: 2022 update. *Annals of the Rheumatic Diseases* 2023;82:19-34.
2. Navarro-Compán V, Ramiro S, Landewé R, et al. Disease activity is longitudinally related to sacroiliac inflammation on MRI in male patients with axial spondyloarthritis: 2-years of the DESIR cohort. *Annals of the Rheumatic Diseases* 2016;75:874-878.
3. Navarro-Compán V, Ramiro S, Landewé R, et al. In patients with axial spondyloarthritis, inflammation on MRI of the spine is longitudinally related to disease activity only in men: 2 years of the axial spondyloarthritis DESIR cohort. *Annals of the Rheumatic Diseases* 2018;77:470-472.

Safe Minimum Staffing Levels On A Medical Ward

Noor-e-Maham Shakeel (IMT-1), Arash Fattahi (IMT-2), Sourjya Kar (Consultant Nephrologist)

Introduction

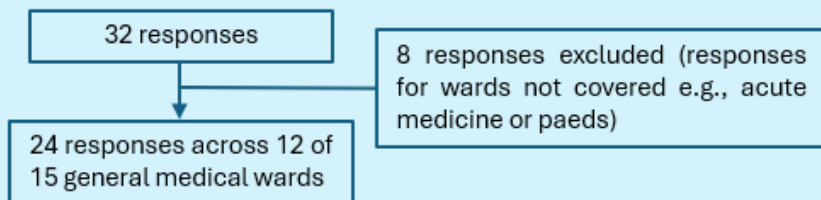
The Royal College of Physicians' (RCP) report¹ on safe medical staffing provides estimates on the number of resident doctors required for different shift schedules and clinical settings. They estimate for a 30-bed medical ward, 2.2 tier 1 doctors (clinicians below registrar level) and 1 tier 2 doctor (clinicians at registrar level) are needed. These recommended staffing numbers should be validated or adjusted according to appropriate internal audits. We as Associate College Tutors (ACT) have audited this in Northampton General Hospital (NGH) by utilising a variety of data points to determine the minimum staffing level per medical ward.

Background and Methodology

Current medical rotas at NGH allocate a minimum of 1-2 doctors per ward, disregarding workload variations. We defined ward-specific minimum safe staffing by integrating objective exception reports, junior doctor feedback, and ward-level workload modelling. This was achieved by collecting information on crash call frequency from the resus team and the number of discharges/admissions per ward. Data was collected monthly from April 2023 to March 2024 across 15 general medicine wards as our department of interest. The RCP benchmarks on tier 1 and tier 2 doctors were applied to each ward. Uplifts in minimum ward staffing were done if either the crash call frequency or admission/discharges were more than average (calculated over all wards). A survey was sent to resident doctors to get feedback on their views on minimum staffing levels. Additionally, we also looked at exception reporting to see if understaffing effects were manifesting as exception reports and thus highlighting the importance for change.

Results

Feedback from resident doctors supported this change (uplift in minimum staffing number) and reasoning was similar to comments raised in exception reporting. Moreover, reported ward acuity in feedback reporting correlated to higher numbers of crash calls experienced on the ward.



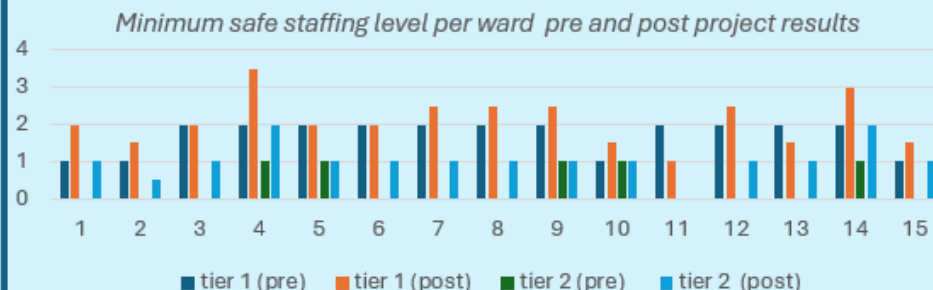
22 responses (91.7%) did not think a minimum staffing level of 1-2 was appropriate for their ward which supports the data shown.

2 responses from 2 separate wards felt minimum staffing of 2 was appropriate. Following this, uplift of minimum staffing level was done in both wards from 1 to 1.5. An uplift to 1.5 means 2 doctors are needed in the morning and 1 in the afternoon.

Ward workload modelling was based on:

1. Number of beds per ward
2. Average monthly crash calls
3. Average monthly admissions/discharges

Crash calls and admissions/discharges were averaged across all wards; a ward whose data were above the average was identified as needing increase in staff numbers. If this was for the crash call domain, then registrar minimum number was increased, as this was used to reflect acuity on a ward and thus the need for senior support.



Minimum staffing per ward is 1-2 resident doctors (lower than IMT3). This was irrespective of patient number, patient acuity or discharge numbers.



Conclusion

A data-driven, multifaceted approach combining quantitative exception reports, qualitative feedback, and workload modelling enables precise determination of minimum safe staffing per ward. Our analysis showed that it is important to contextualise RCP benchmarks using real world data and to set tailored minimum staffing for each ward accordingly. Sharing these evidence-based techniques can help ACTs optimise rotas, enhance patient safety, improve educational support for trainees, and promote junior wellbeing.

The changes to staffing level has been communicated to the junior doctor admin team and should be the new requirement that NGH will operate at.

Exploring the Lived Experiences of Informal Caregivers in Hyderabad, Pakistan: A Qualitative Study.

AUTHORS

Dr Sughra Mahnoor Mangrio

¹ Health Services Academy, Islamabad, Pakistan ² Russells Hall Hospital, Dudley, UK



01. INTRODUCTION

Pakistan's elderly population is projected to exceed **12% by 2050**, yet formal elderly care services are scarce. Especially in urban centres like Hyderabad. Informal caregivers primarily family members bear the physical, emotional, and financial burden of care.



02. OBJECTIVE

This study explores the lived experiences of informal caregivers in Hyderabad, identifies caregiving challenges, and examines how gender and health-system limitations shape those experiences.



03. METHODOLOGY

- Design: Qualitative, exploratory.
- Sampling: Purposive sampling of informal family caregivers.
- Setting: Civil Hospital Hyderabad (Liaquat University Hospital).
- Data collection: In-depth, semi-structured interviews caregivers providing unpaid support to elderly.
- n = 11 adult 7F/4M; Age 20-45, informal caregivers (unpaid).
- Procedure: Interviews audio-recorded and transcribed verbatim.
- Inclusion/Exclusion: Primary unpaid caregivers of relatives with chronic illness/disability; excluded non-caregivers or those unwilling/unable to consent.
- Analysis: Manual thematic analysis to code data and identify recurring patterns across interviews.
- Saturation & rigour: Sample size guided by thematic saturation; standard steps for credibility and confidentiality.



04. RESULTS

Six major themes emerged:



Equity note:
Female caregivers were disproportionately affected due to entrenched gender norms.



05. CONCLUSION

The study highlights significant unmet needs among informal caregivers in Pakistan. There is an urgent need for policy interventions such as caregiver training, community-based support, elder-specific healthcare infrastructure, and financial subsidies to reduce caregiver burden.

06. IMPLICATIONS

- Respite care + counselling
- Caregiver allowance / paid leave
- Elder-care clinics (geriatrics, OT/PT)
- Telehealth follow-ups
- Home-care/community nurses
- Brief caregiver training at hospitals.

Is the UK Foundation Programme fit for purpose in sustaining doctor–researcher careers?

A narrative review and policy analysis

Mohammed Azib Zahid¹

¹. Southend University Hospital, MSE Trust

Introduction

Clinician-led research drives NHS quality and innovation; the UK clinical academic workforce is **contracting and ageing** (~3,090 FTE in 2024; ~3.4% of consultants; ~0.9% below consultant level) [1]. The Foundation Programme (FP) is the universal entry point after graduation.

Question: Does FP provide time, training, mentorship and access for all F1–F2 to begin research pathways?

Methods

Narrative review (May 2021–Aug 2025) of primary sources:

- UKFPO/GMC FP Curriculum 2021 (research/scholarship; FPC13) [2].
- NHS England ICB annual assessment guidance (statutory research duty; KLOEs on facilitating/promoting/using research/innovation) [3].
- MSC clinical academic workforce update (2025) [1].
- UKFPO F2 Career Destinations Survey 2024 [4].
- NIHR Associate PI Scheme documentation [5].
- Deanery study-leave policies (West Midlands; Severn) [6,7].
- UKFPO SFP overview and 2025 SFP recruitment arrangements [8,9].

Thematic synthesis: **access, time, training, mentorship, policy levers, pipeline outcomes.**

Results

Curriculum intent vs reality

FP curriculum embeds research & scholarship; F2 may recruit for and/or conduct original research (FPC13) but there is no mandated protected research time or universal methods requirement [2].

Time/access during F1–F2

F1 time largely pre-committed to teaching; study-leave budgets limited or absent; tasters (≤5 days) often borrowed from F2 → research participation atypical in standard posts [6,7].

Scale of academic exposure

SFP provides structured opportunities but reaches a minority (8.3% of 2024 F2 respondents; 18% response rate) [4]. 2025 recruitment in England shared between medical schools and PIA [9].

Early-career route outside curriculum

NIHR Associate PI Scheme: ~6-month, in-work trial experience with certification; availability is site/study dependent (not universal) [5].

Policy lever now available

ICBs assessed on how they facilitate, promote and use research/innovation → actionable route to commission and performance-manage protected time, mentorship, and NIHR portfolio participation within FP delivery [3].

Interpretation

FP is partly fit for purpose (scholarship/QI assured; SFP strong for its cohort) but insufficient for most trainees given pipeline data [1–2,4].

Conclusions

Actionable reforms

Protected entitlement for all F1–F2 (e.g., 0.5 day/fortnight or 1 week/rotation) with e-portfolio evidence mapped to Domain 9/FPC13; rota compliance monitored [2,3].

Universal skills: brief methods + GCP (e-learning acceptable) to enable NIHR portfolio contribution [5].

Mentorship & visibility: named mentor for every FD + a live local study menu (NIHR portfolio; Associate PI-eligible) refreshed quarterly [5]. Scale SFP to ≥10–15% over 3–5 years; pilot longitudinal micro-placements (0.5 day/week) aligned to 2025 recruitment arrangements [8,9].

Recognition: credit verified research activity (Associate PI completion, ethics submissions, portfolio delivery) in ARCP and early-career selection [10].

- 1 Medical Schools Council. Urgent intervention needed to address decline in clinical academics. London: MSC; 2025 Jul 15.
- 2 UK Foundation Programme. The Foundation Programme Curriculum 2021. London: UKFPO; 2021.
- 3 NHS England. Annual assessment of integrated care boards 2024/25: supporting guidance. London: NHS England; 2025 Jun 17 (updated 2025 Jun 27).
- 4 UK Foundation Programme Office. 2024 F2 Career Destinations Survey report. London: UKFPO; 2025 Jun 17.
- 5 National Institute for Health and Care Research. Associate Principal Investigator (PI) Scheme: overview. London: NIHR; 2025 [accessed 2025 Aug 9].
- 6 NHS England West Midlands. Foundation study leave guidance (F1/F2). Birmingham: NHSE WM; 2025 Apr.
- 7 NHS England South West (Severn). Study leave – Foundation. Bristol: NHSE SW (Severn); 2025 Apr 15.
- 8 UK Foundation Programme. Specialised Foundation Programme (SFP): overview. London: UKFPO; 2025 [accessed 2025 Aug 9].
- 9 NHS England; Medical Schools Council. NHS England and MSC to manage SFP recruitment for 2025 (England): joint announcement. London: NHSE/MS; 2024 Aug 22.
- 10 Royal College of Physicians. Making the case for research: resource kit for doctors. London: RCP; 2025 May.

