Health Education North Central and East London
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Developing people for health and healthcare

Pan-London Quality and Regulation Unit

Chelsea and Westminster Hospital NHS Foundation Trust

Core Medical Training

Quality Visit Report

Date of visit: 19 May 2015

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Health Education
North West London

SPECIALTY-FOCUSED VISIT REPORT

Visit Details	
LEP	Chelsea and Westminster Hospital NHS Foundation Trust
Specialty	Core Medical Training
Date of visit	19 May 2015
Background to visit	The Head of the London Specialty School of Medicine requested to conduct a specialty focused visit to core medical training since this specialty had not been visited for several years. Furthermore, given the Trust's deteriorating General Medical Council National Training Survey (GMC NTS) results, it was decided that the Trust's training environment needed to be assessed to ascertain if it could adequately support training. In the 2014 GMC NTS there was a red outlier for 'adequate experience'. In the same survey results it was also concerning to see that 'access to educational resources' had changed from a green outlier into a red outlier within three years of survey results.
Visit summary and outcomes	At the visit, the visit team felt that the Trust had made significant progress in addressing the issues raised in the 2014 GMC NTS, for example the Trust and departmental induction had clearly improved. The visit team summarised the following positive points in the feedback session at the end of the visit. • All the trainees knew who their educational supervisor and clinical supervisor was and felt well supported. • All the trainees felt that they were able to meet their curriculum requirements, for example they attended clinics and were able to ensure that practical procedures were signed off. • The period of time spent in the emergency department was felt to be useful (although the visit team felt that consideration should be given to shortening this attachment to four months). The trainees reported that they were given the opportunity to work in the resuscitation area and therefore had sufficient exposure to major cases. • The visit team was pleased to hear of the clinic week in the acute assessment unit block when trainees could choose which clinics to attend and therefore could develop skills in areas that they were interested in; this dedicated clinic week also allowed them to meet their curriculum requirements. • The research week was also commended by the visit team. This week allowed the trainees to follow up on patients that they had been treating during the clinic week the week before and participate in research and complete audit and quality improvement projects. • The trainees were particularly complimentary about the Schwartz rounds which they felt were very useful. They also reported that they were able to be autonomous while working in the downstream wards, but that support was available if required. • There was extremely high praise for Practical Assessment of Clinical Examination Skills (PACES) teaching, with one consultant being available to

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	teach the trainees on a daily basis. This was in addition to the training they received in collaboration with the Royal Brompton Hospital site and at the Royal Marsden Hospital site. • The trainees were happy with the quality of clinical experience they received and the mortality and morbidity meetings were highlighted as particularly useful as an arena to discuss and clinical concerns and incidents The visit team expressed concern however about handover, particularly the Monday morning handover. There was a perceived risk by trainees that outlying patients could become lost in the system. The visit team was informed by the Trust that the handover process was already being reviewed. Finally, although the visit team heard about robust clinical governance processes from the senior executive team, it was felt that the trainees were not always involved in these processes. Trainees did not always receive feedback from serious incident investigation outcomes but reported being well supported within the investigation process.

Visit team

Lead Visitor	Dr Karen Le Ball, Head of the London Specialty School of Medicine	**Lead Provider Representative**	Dr Orla Lacey, Lead Provider Deputy Director, Imperial Healthcare NHS Trust
External Representative	Dr Penelope Smith, Royal Free London NHS Foundation Trust	**Trainee Representative**	Dr Emily Gowland, Trainee Representative
Visit Officer	Mrs Jane MacPherson	**Lay Representative**	Mrs Jane Gregory

Findings

GMC Domain	Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
6	CMT 5.1	**Training environment** The visit team heard that an interim chief executive had been in post since November 2014. The executive team informed the visit team that the hospital was back in a good functional place following many changes in the previous two years, for example a new college tutor in medicine and the appointment of a new college tutor for core medical training (CMT).		

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		The visit team heard that there was a strong and committed postgraduate education team which communicated well with the departmental local faculty groups. The executive team reported that there had been a steady increase in activity at the Trust which was largely driven by demographics but that there had not yet been any significant changes caused by the North West London 'Shaping a Healthier Future' programme. The core medicine trainers felt that the environment was ideal for the trainees to train as there was sufficient but not excessive workload. The self-contained nature of the hospital and interesting specialties were also considered to be conducive to a positive training experience.		
1	CMT1.1	**On call** The visit team heard that core medical trainees covered night-time on call when they were undertaking the specialty attachments but that when they covered the acute assessment unit (AAU), they did not cover nights. The night rota consisted of a split week with trainees covering Monday to Thursday either days or nights and then Friday to Sunday either days or nights. They were on a one in 14 on call rota. The visit team heard that the on call at night was busy and that trainees had the opportunity to see a variety of cases. The trainees felt that the emergency department (ED) had become busier following the closure of the ED at Hammersmith Hospital. Previously while on duty at night the trainees may only have seen as little as three patients overnight whereas at the time of the visit they reported that they were seeing up to 18 patients per night. The trainees reported that they always had the opportunity overnight to present the patients to the higher trainee. They could also present the patients at the post-take ward round in the morning between 8am and 9am as the consultants were present. They commented that the consultants were prepared to see the post-take patients earlier in the morning so that the trainees could finish their shift on time.		

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		It was reported that there was an electronic system for handover. All overnight admissions stayed on the AAU until they were picked up by the AAU team. The handover from AAU to the ward was conducted later on verbally. At times, especially at the weekend, patients who were admitted on the twilight shift by a foundation year one trainee were later handed over to the night person who would then hand over to another day person. The trainees felt that the handover at 9am on a Monday morning meant that some of these patients were not picked up immediately by the ward based teams and was therefore not reliable since the AAU team did not know the patients and were not given a sufficiently in-depth hand-over. The trainees reported that they had raised patient safety concerns about the transfer of patients from the AAU to the ward. The trainees commented that at times different teams overlapped on the same ward and it was not always clear who was responsible for which patients. They felt that sometimes there were outlying patients who could be lost. The visit team heard from the trainees and trainers that an on-going audit (involving trainees) was already taking place to try and improve the handover process. The trainers confirmed that the audit was being run by a core medical trainee and a senior higher trainee to try and address this issue. Discussions were also taking place with the foundation school. They agreed that further work needed to be carried out to ensure that the handover was sufficiently robust but commented that there was no perfect system.	Provide results of audit / project to the Pan-London Quality and Regulation Unit, including the plan for Trust-led improvement of handover.	**Amber** Mandatory Requirement
1	CMT1.2	**Serious incidents** The chief executive reported that there was a very strong culture of learning from serious incidents and that clinical governance held a prominent place in the senior medical management team and agenda. It was reported that different methods of feeding back about incidents were in place, for example via newsletters, handovers, tips of the week, agenda items at quarterly meetings. The visit team was heard that the Trust was in the process of purchasing an electronic incident reporting system which should be operational by the end of the year this would enable those reporting incidents to follow the progress of the investigations	Review and strengthen the serious incident policy and process to ensure that trainees are kept fully abreast of all incidents and the learning opportunities which they present. Please could the fellow provide an update as to what is proposed to facilitate this communication and support the dissemination of learning from serious incidents. Please provide revised serious incident policy and evidence of how	**Amber** Mandatory Requirement

		The director of medical education (DME) reported that she had appointed a fellow who would be trying to ensure that communication around serious incidents was more robust and that trainees could understand the process. Serious incident reports were reported to be anonymised and published on the intranet. Trust-wide quarterly clinical governance meetings took place during which incidents were discussed. The clinical lead for acute medicine reported that there was a weekly 90 minute meeting, half an hour of which was spent discussing feedback and learning from generic incidents. The other hour was used for teaching in addition to a mortality and morbidity meeting. The visit team heard that the meeting was very open, that trainees had the opportunity to present cases and that everyone felt comfortable bringing issues up. The clinical director reported that any incidents raised would be brought to her attention, and that after they had been investigated, the details would be fed back to the trainee involved and then to everyone else at the weekly meeting. The college tutor reported that serious incident reporting mechanism was included in induction. Any serious incident reports would be forwarded to the medical director who would discuss these in the monthly medical directorate meeting, which was also attended by a trainee representative. Some trainees reported that they had not received feedback from incident forms they had submitted. Others had received verbal feedback. The trainees confirmed however that incidents were discussed at the weekly AAU meeting in acute medicine. All the trainees reported that they had absolutely no concern about being able to raise issues in meetings.	learning opportunities are disseminated.	
2	CMT2.1	**Local faculty groups**		

		The trainees confirmed that at the beginning of the weekly teaching session on a Wednesday, there was a meeting where they could raise issues about training with the training programme lead /college tutor for CMT. The trainees knew who their trainee representative was and said they received regular and appropriate feedback from the meetings she attended on their behalf. The trainees reported that the DME had met with them the previous year to discuss and explored the issues which had been raised in the GMC survey and was clearly keen to improve the quality of their educational opportunities.		
6	CMT6.1	**Induction** All the trainees confirmed that they had attended a Trust and departmental induction. The core medical induction was reportedly very good with Dr Wahed being highlighted as particularly helpful and supportive. A useful induction booklet had been produced.		
6	CMT6.2	**Educational supervision** The executive team indicated that job plans were still a work in progress. It was reported that a company was currently streamlining supporting professional activity (SPA) time to ensure that consultants were being remunerated properly for the work they were undertaking. In terms of meeting the requirements for training leading to the recognition of educational supervisors, the Trust was at 92% compliance rate at the time of the visit. The college tutor confirmed he had time in his job plan for his role. Other educational supervisors reported receiving 0.25 programmed activity (PA) per trainee in line with the requirements of the London Professional Development Framework. It was reported that the majority of educational supervisors supervised two or three trainees. The majority of the trainers were satisfied with this arrangement.		

		The trainees spoke very highly of their educational and clinical supervisors, with Dr Skene being highlighted as particularly engaged in the trainees' portfolio. Some trainers reported that there had been a reduction in educational supervision time and some found it hard to fit it into their schedule. The trainers confirmed that regular courses were run to ensure that they were trained properly. Trainees in difficulty were reportedly discussed at consultant meetings each week. Any issues would be flagged up to the educational supervisor who would also speak to the college tutor. The college tutor confirmed that he escalated any trainees in difficulty to the DME and the North West training programme director.		
6	CMT6.3	**Training** The college tutor reported that there were eight trainees in post. Two rotated on a six month basis between acute medicine and the emergency department and the others rotated for four months between rheumatology, geriatrics, gastroenterology, genitourinary medicine and human immunodeficiency virus (HIV) training. The visit team heard that there had been recent changes to the acute medicine job to try and improve training opportunities. The changes to the rota had been facilitated by the addition of acute care common stem (ACCS) and emergency medicine (EM) trainees to the rota. Ambulatory care hot clinics had been introduced and there were plans for this team to also take over day care which would mean even more clinical experience for the trainees. In addition, a clinic week had been added to the timetable which meant that trainees could have tailor-made training for one week in a nine week rolling rota – they could choose where they wanted to spend this time depending on their specialty preference. As part of the rota, the trainees were rostered to the following areas: the medical high dependency unit, covering on-take, covering the inpatient parts of acute medicine, the ambulatory care week, a clinic week and a research week. At the end of a four month period, it was expected that		

		trainees had completed a good audit. At the end of a six month period, it was expected that trainees were able to submit an academic paper. Following the clinic week, the trainees always had their research week which meant that they had the opportunity to follow up on the clinic patients that they had seen the previous week. The college tutor reported that the trainees were directly involved in ED and resuscitation cases whilst working in the emergency department and that attempts were made to ensure that the trainees had exposure to major cases. Although the majority of the core medical trainees found the emergency medicine rotation useful, and were able to learn all about the process for receiving referrals, the clinical director suggested that the period of time spent in the emergency department could be shortened to four months. He had not however received any negative feedback about the emergency medicine rota from the trainees. The trainees on specialty attachments all had dedicated clinics, for example in gastroenterology the trainees attended one clinic per week. Similar to in acute medicine, arrangements in gastroenterology had been made for the trainees to spend an additional week of the rota concentrating on work that they were interested in. The college tutor felt that there was no obstacle to the trainees achieving their 12 clinics per year curriculum requirement and he also said that they would be able to meet 20 if this requirement were mandated. The trainees confirmed that they had no problem achieving the appropriate number of clinics for the year. They also felt that the addition of the ambulatory care week had improved their training. The visit team heard that for the most part the trainees' leave was built into the nine week rota, and that the trainees were able to swap in and out as they wished. When on the AAU, the trainees had a fixed rota with fixed leave built in, but the rest of the time they were able to take annual leave whenever they wanted. Some trainees who had been in the Trust before reported seeing vast improvements to the		

		training programme since the previous GMC NTS results had been issued. They felt that induction, teaching and experience had all improved. They also commented that since the acute medicine rota had been broadened to include ACCS and EM trainees, their overall training experience had improved. They also highlighted motivated higher trainees and proactive consultants as being a contributing factor to their positive training experience. The trainees reported no issues with completing their required curriculum competencies. They also commented that they had the opportunity to participate in one-to-one training in a skills laboratory with a teaching fellow if they felt they needed additional practice with practical procedures. The core medical trainees had exposure to acute cardiology even though they did not undertake a specific cardiology rotation in core medical training year one.		
6	CMT6.4	**Teaching** The visit team heard that there was a robust teaching programme on a Wednesday lunchtime, which also tied in with cross-site teaching at the Royal Marsden Hospital and the Royal Brompton Hospital. The trainees reported that they had good teaching on a weekly basis and that their training was tailored to their needs. They were also able to attend the regional teaching days. The consultants reported that they encouraged the trainees to attend. The trainees reported that they had not attended any local simulation training, nor had they received any formal ultrasound training which the trainers and trainees thought might be useful. Most of the teaching was reportedly bleep-free. Even when the trainees were covering the acute take, since it was usually quiet in the morning, they were able to attend the teaching sessions. Most departments reportedly ran departmental teaching sessions plus a grand round.		

		The visit team heard that the Trust had achieved a 98% pass rate for Practical Assessment of Clinical Examination Skills (PACES) in the last nine years. The trainees spoke very highly of Dr Bartholomew who they said taught them on a daily basis. He was reported to be always available and always keen to teach even when he was supposed to be on holiday. Some trainees were interested in attending training in the intensive treatment unit (ITU). The trainers reported that the trainees were able to request experience there if they wanted to but that this was not part of the rota.		
6	CMT6.5	**Preparation for higher training** The trainees reported that they were given the opportunity to manage the wards autonomously but with support, if required. The core medical training year two trainees reported that they were able to act up as soon as they passed their exams. They found this experience very useful and felt well supported.		
6	CMT6.6	**Schwartz rounds** Several trainees confirmed that they had been involved in Schwartz rounds and found them very useful.		
6	CMT6.7	**Do Not Attempt Resuscitation** The trainees reported no issues with getting the Do Not Attempt Resuscitation forms signed. Most were happy with the amount of training they had received and felt comfortable having discussions with patients and families about end of life matters. Training was carried out by a palliative care consultant and there was also an acute oncologist who was very active in the AAU.		
6	CMT6.8	**Bullying and undermining** The DME reported that reflection training had been conducted with particular individuals where bullying and undermining accusations had been made.		

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		During induction, the trainees were sign-posted to speak to the DME if they felt that there were issues of this type with someone in their department. Although courses for new consultants were in place, the Trust reported that it was also keen to introduce a formal mentorship programme for new consultants. The trainees reported no issues with bullying and undermining and generally considered their trainers to be approachable and friendly.		
6	CMT6.9	**Mental Health Act and equal opportunities** The visit team heard that a psychiatric liaison nurse trained the trainees on matters relating to the Mental Health Act, including assessments and restraints. It was reported that this training took place very early on in their post. The trainees confirmed that this was the case. The trainees also confirmed that there were no issues with regards to the equal opportunities framework.		

Good Practice	Contact	Brief for Sharing	Date
Some of the trainers were highlighted as being particularly approachable, motivated and keen to teach, for example Dr Bartholomew, Dr Skene and Dr Wahed in his role of supporting the trainees as college tutor. The research and clinic blocks in the AMU were very innovative and highly praised by the trainees. It enabled then to meet the curriculum requirements and gain exposure to specialties of their choice which may not otherwise feature on their rotations. The research weeks enabled them to complete projects and be involved with departmental initiatives. Weekly AMU meetings which discussed mortality incidents and clinical issues on a very level un-hierarchical way empowered the trainees to provide constructive feedback and voice concerns without the possible fear of victimisation.	Dr Gary Davies Dr Gary Davies	Please may the Trust give a summary of the research and clinic blocks. Please may the Trust give a brief summary on the AMU meetings including the structure and who leads them etc.	31/08/15 31/08/15

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Other Actions (including actions to be taken by Health Education North West London)	
Requirement	**Responsibility**
Local Education and Training Board (LETB) to consider and seek more guidance from the Royal College of Physicians (RCP) regarding the requirement for and provision of ultrasound training.	Karen Le Ball

Information and reports provided to the team prior to the visit							
DME Annual Report	*No*	Regulator Reports/Data	*Yes*	LFG Reports	*No*	MEM minutes	*Yes*
GMC Survey - trainees	*Yes*	GMC Survey - trainers	*No*	Previous visit reports & action plans	*Yes*		
PVQs - trainees	*Yes*	PVQs - trainers	*No*	Result of school survey	*No*		

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Karen Le Ball*
Date:	*8 July 2015*