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Pan-London Quality and Regulation Unit

Imperial College Healthcare NHS Trust
Core Medicine Training
Specialty Focused Visit

Quality Visit Report

3 November 2015

Final Report

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Visit Details	
Trust	Imperial College Healthcare NHS Trust
Date of visit	3 November 2015
Background to visit	Core medicine had not been formally visited for five years. The Head of School of Medicine requested to align with the quality visit to Imperial College Healthcare NHS Trust as it was a good opportunity to review the specialty. The specialty had not been a particular concern in the 2015 General Medical Council National Training Survey; Hammersmith Hospital had generated pink outliers in supportive environment and feedback.
Visit summary and outcomes	The visit team met with the training programme directors for St Mary's Hospital, Hammersmith Hospital and Charing Cross Hospital and the director of medical education for the medical division. The visit team met with over 20 trainees in core medicine across both core training (CT) year 1; CT1 and CT2 and working at Hammersmith Hospital, Charing Cross Hospital and St Mary's Hospital, this was followed by a meeting with the educational and clinical supervisors. Feedback was provided to the senior management team and educational leads. The visit team found that the trainees were very positive about renal medicine at Hammersmith Hospital; although there was a heavy workload they were positive about the experience they received. The trainees also praised the training posts in intensive care medicine (ICM). The visit team found that there was a variance in the regular attendance of trainees to clinics. It was reported to work best for the trainees who had a scheduled block, either a full day or full week, timetabled onto the rota. The trainees reported concerns with the induction process, particularly at St Mary's Hospital and Charing Cross Hospital. The local induction was highly variable across the Trust. There were variances in the quality of induction at Hammersmith Hospital; the trainees reported that the renal induction was excellent, whereas, the induction in cardiology was a brief discussion with a specialty registrar. The induction was also a particular concern for trainees starting at St Mary's Hospital on a night shift. It was clear there were ample amounts of teaching on offer, but the teaching sessions were not bleep free. Trainees were not able to attend regional training days or attend local teaching at St Mary's Hospital. The visit team heard that the core medicine teaching in the Trust included the attendance of foundation trainees. Although it was a good opportunity for the trainees to interact, the sessions were often on topics that did not challenge the core trainees. The visit team found that not all trainees had an allocated educational supervisor or a named clinical supervisor for each placement. The visit team recommends that trainees had the same allocated educational supervisor for 12 months. Serious patient safety concerns were highlighted in the acute medicine department at Charing Cross Hospital, where a large number of patients were not routinely reviewed by a consultant. An immediate mandatory requirement was issued to the Trust to ensure that all patients had a named consultant and were regular reviewed. Core medical trainees must be supervised in managing this patient group.

Visit team			
Lead Visitor	Dr Catherine Bryant, Deputy Head of London School of Medicine	**External Representative**	Dr Sheena Mitchell, Director of Medical Education, The Whittington Hospital NHS Trust
Lead Provider	Dr Jo Szram, Core Medicine Training Programme Director for Imperial College Healthcare	**Trainee Representative**	Dr Emily Gowland, Medical Education Fellow
Lay Member	Diane Moss, Lay Representative	**Visit Officer**	Michelle Turner, Quality and Primary Care Manager

Findings			
Ref	**Findings**	**Action and Evidence Required.** **Full details on Action Plan**	**RAG rating of action**
GMC Theme 1) Learning environment and culture			
CM1.1	**Patient safety** The trainees in acute medicine at Charing Cross Hospital stated that there was only one substantive acute medicine consultant in post. The consultant was also the clinical lead, and training programme director for the site. The physician of the week rota in the acute medicine ward changed weekly, the experience was fantastic for trainees, but the lack of continuity was not helpful. The consultants changed on a weekly basis so trainees found that there was a lack of consistency. The trainees reported that there could be up to 40 patients on outlying wards, who were reviewed daily by the foundation year two (F2) or core training year one (CT1) trainee. Due to the high number of patients on outlying wards, and the lack of substantive acute medicine consultants, many patients were not reviewed by a specialty training grade or equivalent grade Trust doctor or consultant daily. The visit team heard of incidents when a patient had not been reviewed for up to 12 days by a consultant There was a daily board meeting at 11am and the trainees would highlight patients to be discharged. The consultants always asked the core medicine trainees the clinical status of patients and as a priority would review the unwell patients based on the core trainee recommendations; there was no routine review of all outlying patients by a consultant. The visit team heard of incidents when trainees had been reviewing patients during the day, but by 6pm they had to make a decision on which of the remaining patients to hand over to the on call team as to which patients required urgent review. The trainees reported that this was a well-known problem within the Trust; the management were well aware of the concerns and were making steps to address it. The educational supervisors reported that the department was aware of the concerns in acute medicine. The Trust was reallocating a ward to medicine at Charing Cross Hospital which would reduce patients on outlier wards by 20. There was shortage in consultant manpower, the trainee doctors had been a huge help in continuation of care in the department. The core medical trainees reviewed all patients on a daily basis, and had recently been asked to keep a record of when each patient was last reviewed by a consultant. If a patient was not seen one day they would be prioritised for the following day. The visit team heard that often it was difficult to move patients once they were on an outlier ward, it often took a lot of effort to transfer to the specialist wards. The patients who were admitted through the emergency department took priority above other patients. The educational supervisor stated that the majority of the patients selected for the outlier wards, were not acutely unwell, and generally were in the hospital because of “social issues”.	Acute medicine at Charing Cross Hospital has a large number of outliers discussed at the Board round but patients are not routinely seen by a consultant. All patients must have a named consultant and patients must have regular consultant review. Core medicine trainees must be supervised in managing this patient group.	**Red** Immediate Mandatory Requirement

	The educational supervisor reported that the number of patients on outliers ward was between 30 and 40. The department was trying to review the care model used and to increase consultant numbers.		
CM1.2	**Appropriate level of clinical supervision** The trainees in acute medicine at Charing Cross Hospital stated that the consultant was approachable and supportive, but there were up to 20 trainees including core medicine, foundation year 1 (F1) and foundation year 2 (F2) and acute care common stem (ACCS) trainees so the acute medicine lead had many trainees to clinically supervised work with.		
CM1.3	**Responsibilities for patient care appropriate for stage of education and training** The core medical trainees confirmed that they had not been required to work beyond their level of competence.		
CM1.4	**Rotas** The trainees at Charing Cross Hospital stated that the rota was well written. The trainees worked in teams on call. The CT2 trainees stated that they enjoyed the experience of the on call rota, as they worked with the F1 and F2 trainees and had a good opportunity and experience of feeling senior, and to step up into their role. This worked well. The neurology trainees at Charing Cross Hospital stated that they were part of the general medicine on call rota. The workload out of hours was ward based, chasing departments for scanning, blood tests etc. the trainees stated that they had learnt a lot on the general medical rota, the hours were long but provided a good experience of medicine, although lacked specific training in neurology. The trainees reported that they were not sure if the rotas were European Working Time Directive (EWTD) compliant. The trainees reported that the day-to-day hours were filled with general workload from the wards. They often used the zero days on the rota to attend teaching sessions or clinics; they indicated that this was the only way to meet the curriculum requirements. The trainees stated that they sacrificed their days off to ensure that they developed professionally. The trainees on call at St Mary's Hospital stated that the rota was single night shifts, and there were no block shifts. The trainees stated that there was good clinical cover out of hours across the Trust but the training was compromised because of this. The CT1 at St Mary's Hospital stated that the rota was the lightest on call they had been a part of, they had completed only 14 nights over six months which had limited their experience of general medicine. However, other trainees reported that they had a heavy on call rota. The trainees working in the geriatric team were attached to the endocrinology team for acute experience. The team had a lot of take patients, which had resulted in them being able to complete a high amount of workplace-based assessments. The visit team heard examples of how the rota across the sites and specialties was unbalanced.	There is a variance in the regular attendance of trainees to clinics. It was reported to work best for the trainees who had a scheduled block (full day or full week) timetabled onto the rota. The Trust must ensure that all core medical trainees have timetabled clinic attendances to fulfil their curricula requirements. Evidence provided can be in the form of trainee feedback at Local Faculty Group meetings and trainee progression at Annual Review of Competency Progression.	**Amber** Mandatory Requirement

	The clinical and educational supervisors reported that there were many different models of rotas across the Trust for the core medical trainees. St Mary's Hospital operated two levels of rota, a high intensity rota and low intensity rota, the visit team heard that the rota was complex and not easily explained.		
CM1.5	**Induction** The training programme directors stated that there was a thorough induction programme; all trainees attended a Trust induction, and then local departmental induction at each site. All core medical trainees reported that they had received a thorough Trust induction. The visit team heard of many variances in departmental inductions across the sites and specialties. The trainees at Hammersmith Hospital stated that the local induction felt like a tick box exercise. The renal medicine induction was reported to be very good. The trainees stated that they received all the required information, and felt well inducted to the department and the role. However, the trainees in the cardiology department had a brief induction which did not prepare them for the role or specialty. Trainees reported having an informal talk to the specialty trainee in cardiology as part of the induction process. In haematology the induction was combined for both specialty trainees and core trainees, the visit team heard that this was a good framework as they got to know the team and their senior colleagues. However, the trainees felt that by the end of the induction, they was not clear on their role within the department, some areas lacked clarity. The trainees at Charing Cross Hospital reported that the Trust induction was disorganised. They had to wait for long periods and queue for identification (ID) badges. The trainees indicated that it was particularly slow to learn the systems. The trainees at St Mary's Hospital reported a similar experience. They stated that the induction was chaos and it took a long time to receive ID badges and log in details, that they was unable to attend the wards until after 4pm. The trainees reported that the local departmental inductions were good. The educational supervisors reported that they asked trainees to provide feedback following the induction and the results fed back into the next induction and the timetable was adapted as appropriate.	The trainees reported concerns with the induction process, particularly at St Mary's Hospital and Charing Cross Hospital. The local induction is highly variable across the Trust. At Hammersmith Hospital, the renal induction was excellent, whereas, the induction in cardiology was a brief discussion with the specialty trainee. The induction was also a particular concern for trainees starting at St Mary's Hospital at night. The Trust must review the quality and delivery of departmental induction and provide evidence in the form of trainee attendance and feedback.	**Amber** Mandatory Requirement
CM1.5	**Handover** The trainees stated that there were various models of handover across the Trust. It was dependent on the specialty the trainee was working in and the structure of the on call rota. The trainees did not report any specific concerns for handover.		
CM1.6	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The trainees stated that their allocated educational supervisors were all aware of the curriculum requirements for the core trainees.		

	The trainees in haematology at Hammersmith Hospital reported that there were no F1 trainees in the department which resulted in the core trainees performing duties of limited educational competencies. The trainees reported that this felt patronising at times, but they understood it was part and parcel of the job. The trainees indicated that on balance, the training was ok. The trainees in renal medicine at Hammersmith Hospital reported that the training was senior led, the benefit of seeing complex patients was a good experience. The trainees in cardiology at Hammersmith Hospital reported that there was no F1 trainee so the core trainee covered the basic roles. The teams were senior led, and the core trainee often felt overloaded completing F1 level workload. The visit team heard that although the hospital now had a Heart Attack centre but only one core trainee covered this role but there were potentially eight junior trainees in the team so the trainees did not routinely have involvement with angioplasty which was a missed opportunity. The trainees reported that there had been a limited phlebotomy staff within the Trust but this had greatly improved with an increase in staff. This had vastly improved the workload of trainees, and resulted in them having a better training experience. The trainees reported that some wards had recruited physician assistants. The trainees had been led to believe that they would be able to complete a multitude of tasks but it appeared to mainly be phlebotomy. The lack of junior cover on the wards resulted in trainees rarely having time or availability to attend clinics. The clinical and educational supervisors commented that the trainees were able to attend clinics of their choosing which was good for curriculum exposure. Many of the trainees had allocated sessions on their rota to attend clinics. The visit team heard that trainees had ample opportunities to perform procedures, such as chest drains and ultrasound. The clinical and educational supervisors stated that there were ample opportunities for bedside teaching. Many of the trainees were able to present patients on the ward round. For trainees coming towards the end of CT2, they were encouraged to act up and take on more responsibility in the ward round.		
CM1.7	**Protected time for learning and organised educational sessions** The educational supervisors reported that trainees were able to attend regional training days. Some specialties had the training days set into the rota, other specialties did not have automatic release to training days, but with notice the trainees were able to attend. The educational supervisors at Hammersmith Hospital stated that the trainees had fixed time for leave on the rota. Trainees had reported previously that it had been difficult to swap timetabled sessions and that the trainees'' workload could inhibit trainee attendance at regional training days.		
CM1.8	**Adequate time and resources to complete assessments required by the curriculum** The trainees stated that there were huge variances in the ability to complete work place based		

	assessments as part of the curriculum competencies. The trainees in acute medicine at Charing Cross Hospital found this a particular problem as there was no continuity in consultants. The trainees in renal medicine rotated through the department with a consultant and specialty trainee, they had ample opportunities to complete assessments, and they had good working relationships which helped to meet the curriculum requirements. The trainees in haematology at Hammersmith Hospital stated that there were no take patients. The trainees covered the medical ward but not the medical take. The trainees had limited opportunities to present patients or cases to consultants.		
GMC Theme 2) Educational governance and leadership			
CM2.1	**Effective, transparent and clearly understood educational governance systems and processes** The training programme directors commented that there was a lot of interaction between each of the sites. They ensured that they regularly communicated to each other, and discussed the trainees to share information across the Trust.		
CM2.2	**Impact of service design on learners** The training programme directors reported that the service reconfigurations had affected the core medicine trainees and the rotations. There had been confusion with rotational placements resulting from the closure of the emergency department at Hammersmith Hospital and the move of acute medicine. The training programme directors stated that they were disappointed with the decommissioning of posts in cardiology. As the only Heart Attack Centre in the area, they informed the visit team that they could offer trainees good clinical and educational experiences.		
CM2.3	**Appropriate system for raising concerns about education and training within the organisation** The training programme directors confirmed that there was a regular local faculty group (LFG) at Hammersmith Hospital. The core medical trainees were all invited to the specialty LFG. The director of medical education (DME) did not attend all LFG meetings but was sent all meeting minutes. The training programme directors commented that as a group they met fortnightly, but they had struggled to find times to meet together with the DME. The training programme directors reported that there was specialty LFGs across the Trust which core medicine trainees attended. The training programme directors were not able to attend individual LFG meetings, but received the minutes and action plans of all meetings for their site. They often met with the postgraduate administrators to review what had been discussed at meetings and make a plan to address issues.		

	The training programme directors held a quarterly meeting and invited all unit training leads. The meetings were well attended and had given the teams opportunities to join together and raise concerns or share practices. The training programme directors stated that following the re-organisation of the postgraduate centre they had found it a struggle to meet up regularly as there was limited available of administrative support or office space. The visit team heard that some trainees had concerns when starting in post and the rotations; they were able to report and discuss issues with the training programme directors or educational supervisors.		
CM2.4	**Systems and processes to make sure learners have appropriate supervision** The training programme directors reported that they ensured all trainees had the appropriate supervision whilst in post.		
CM2.5	**Organisation to ensure access to a named educational supervisor** The training programme directors confirmed that all trainees had an assigned educational supervisor. They aimed for the educational supervisor to be at the site in which the trainee would be based for the longest period, although this was not always possible. All trainers were aware of the need to discuss training requirements and trainee progression with the allocated educational and clinical supervisor. The trainees reported that they were all aware of who their educational supervisor was. The visit team heard of examples of trainees delayed by up to eight weeks before being allocated an educational supervisor, and others receiving an educational supervisor which were based at a different Trust. A trainee working in acute medicine at Charing Cross Hospital had difficulties when starting in post, as the education centre were informed the trainee was working at Hammersmith Hospital and so were allocated an educational supervisor at the wrong site. The visit team heard that some trainees had rotations which consisted of two placements at another Trust; this resulted in trainees not having an educational supervisor at the Trust. There had been discussions with the trainee to find an educational supervisor at the other Trust due to the majority of the time being there.	All trainees must have a named educational supervisor and a named clinical supervisor for each placement. Trainees should keep educational supervisors for the full 12 months.	**Amber** Mandatory Requirement
GMC Theme 3) Supporting learners			
CM3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees did not report any concerns with undermining or harassing attitudes. Furthermore, they had not witnessed any adverse incidents and felt the Trust was a supportive environment.		
CM3.2	**Timely and accurate information about curriculum, assessment and clinical placements** The trainees stated that they had ample opportunities to conduct quality improvement initiatives.		

	There were no concerns within the Trust with the completion of projects, and the trainees felt actively encouraged to do so.		
CM3.3	**Access to study leave** The trainees stated that they were able to take study leave, and there were challenges with workload and staff availability.		
CM3.4	**Regular, constructive and meaningful feedback** The educational supervisors reported that they were aware of concerns with feedback. All departments and specialty leads were aware of the requirement to provide trainees with regular feedback. They stated that as there was no specialty breakdown for the GMC NTS results, it was difficult to find what specialty the concerns related to.		
GMC Theme 4) Supporting educators			
CM4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The educational supervisors stated that they had all received training for their educational role.		
CM4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The educational supervisors stated that they felt supported from the postgraduate education center to deliver their roles. They had timetabled time in their job plans for their educational role, but indicated the time did not feel sufficient for the work being undertaken. The visit team heard that some trainers felt valued by the Trust whereas, others felt this was less apparent.		
GMC Theme 5) Developing and implementing curricula and assessments			
CM5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The training programme directors commented that there were differences in the amount of teaching on each of the sites. Charing Cross Hospital had core medicine teaching session once per week, an afternoon report and regular grand rounds. At Hammersmith Hospital, there were more trainees and so there was a fixed timetable of teaching. All sessions were advertised on the Trust intranet. There was a dedicated morning report which trainees attended. In addition to the dedicated core training the trainees were also invited to the specialty teaching sessions for cardiology, haematology, renal medicine and oncology. The visit team heard that there had been poor attendance to the teaching at St Mary's Hospital which led to the cancellation of all sessions. The department had decided that as the regional training days were of such a high quality that the local teaching was less important. However, the morning report continued to be well attended. The core trainee presents cases which were then	There is clearly a lot of teaching on offer, but it is not bleep free and trainees are not getting to the regional training days or attending local teaching at St Mary's Hospital. Furthermore, formal teaching for core medical trainees should not include foundation teaching. The Trust is required to ensure that trainees are able to fulfil their curriculum requirements for local and regional training attendance and this should be monitored via LFGs and ARCPs.	**Amber** Mandatory Requirement

	discussed between all staff. There were also monthly morbidity and mortality meetings. Every firm received a regular list of on call mortality rates which were also discussed at audit meetings. The trainees stated that there were issues with the local teaching. Teaching was multi-professional, and F2 trainees from all specialties attended the teaching. The teaching was often attended by a high quantity of foundation trainees, which amended the focus of the sessions. The teaching topics were particularly general which many of the core trainees had covered in previous roles. The teaching did not challenge the trainees. The cardiology trainees reported that teaching was not bleep free, and the busy workload of the department did not allow the trainees to attend teaching. Many trainees had only attended two teaching sessions over a four month period. The trainees in haematology did not have as high a workload as in cardiology, but they still experienced difficulties with attending teaching.		
CM5.2	**Appropriate balance between providing services and accessing educational and training opportunities** The training programme directors stated that all departments had been informed that core medical trainees must be released from their clinical duties to regularly attend specialty clinics. The visit team heard that the core trainees were able to request to attend any of the medical specialty clinics held within the trust. The trainees in acute medicine at Charing Cross Hospital stated that the rota had a heavy clinical workload; they felt that they covered the service provision. They had not been able to attend teaching, as they were aware that if they attended sessions the ward would struggle with no junior doctor. The trainees on the endocrine rota at Hammersmith Hospital reported that they had not been able to attend the regional training day as there was a shortage of staff and the consultants had informed trainees that it was not possible to have locum cover. The trainees in renal medicine indicated that attendance to teaching was challenging but it depended on the rota the trainees were on. The trainees had to organise themselves, but this meant that they could attend often. The trainees in oncology stated that the Charing Cross Hospital job was notoriously busy. The trainees rarely finished on time. The trainees reflected on this, and looked to make improvements. They tried to implement changes but these were overridden by the management. The trainees commented that the morale of the department was low, and the job was rarely enjoyable. The trainees in intensive care unit reported that they felt they had a good experience in the department. They had ample staff, covering the workload. The core trainees often spent long period chasing scans, but they felt supported by consultants who would step it to help when necessary. The trainees in cardiology at Hammersmith Hospital reported that the overall balance was satisfactory. The rota was balanced by regular days off, but the day to day work was intense. The trainees confirmed that the heavy workload had not impacted on or compromised patient safety.	The training programme directors were aware of there being concerns with trainee experience and workload issues in some departments such as renal medicine at Hammersmith Hospital and Oncology at Charing Cross. Evidence that these issues have been addressed, through discussion at LFGs must be provided to the visit team.	**Amber** Mandatory Requirement

	The trainees in haematology at Hammersmith Hospital stated that there was a regular twice weekly consultant ward round, but the patients were rarely reviewed before 4.30/5pm which meant that the ward jobs were rarely completed before 7pm.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**
N/A			

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
N/A	

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Catherine Bryant*
Date:	*8 December 2015*