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Quality and Regulation Unit (London and South East)

Chelsea and Westminster Hospital NHS Foundation Trust
West Middlesex University Hospital
Acute Medicine
Specialty Focused Visit

Quality Visit Report

17 November 2015

Final Report

THE NHS CONSTITUTION
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Visit Details	
Trust	Chelsea and Westminster Hospital NHS Foundation Trust – West Middlesex University Hospital
Date of visit	17 November 2015
Background to visit	Chelsea and Westminster Hospital NHS Foundation Trust acquired West Middlesex University Hospital in September 2015 and since then an integration of services and education and training had been on-going. It was felt that a review of how the integration was progressing and where education was fitting into the realigned services was necessary. This was especially relevant with the increase in patient numbers due to the reconfiguration of service in North West London under Shaping a Healthier Future. In the 2015 GMC National Training Survey (NTS) acute internal medicine at West Middlesex Hospital received three red outliers and two pink outliers. The red outliers were in local and regional teaching and access to educational resources. The pink outliers were in induction and feedback. Based on these GMC NTS results it was decided that there should be a quality visit to the department in order to ascertain the reasons for these issues and to find out how the Trust was rectifying them.
Visit summary and outcomes	The visit team met with the senior management team in the morning, followed by a meeting with the clinical director and college tutor for acute medicine. The visit team then met with the two higher trainees in acute medicine, before meeting with the clinical and educational supervisors and feeding back to the Trust. The senior management team told the visit team that they had invested in nursing staff in an attempt to help resolve some of the workload issues. They also said that they were conducting some strategic work across the Trust looking at the balance between emergency and elective work. They indicated that there were divisional integration groups looking at integration opportunities in each area following the acquisition by Chelsea and Westminster Hospital NHS Foundation Trust. Throughout the day the visit teams identified three immediate mandatory requirements that required urgent action from the Trust within 5 days. These were as follows: • The visit team found that patients were staying on Acute Medical Unit (AMU) for more than 72 hours without there being an automatic trigger for the consultant to see them when this happened; although the patients were discussed at a daily board round it was left to the trainees to trigger a face to face consultant review. • Handover at 8.30am on AMU was poorly attended and there was no consistent consultant presence at this process. This led to patients being transferred both in and out of AMU without appropriate handover. • Patients were being transferred to AMU from the emergency department without being known or seen by the on call medicine team. This had been reported to be happening on a weekly basis and had led to acutely unwell patients being missed. Other concerns raised on the day included the fact that the consultant on call changed each day which led to the higher trainees providing the only continuity of care to the patients, leading to them spending more time on the ward. The visit team also found that trainees were unable to attend the ambulatory care unit or clinics which were a lost training opportunity. The visit team also heard that trainees were unable to attend teaching because of clinical commitments. However the visit team was pleased to find that the consultant body was very supportive to trainees and engaged in training. It was also evident that there was potential for the placements to have a very rich learning experience because of the breadth of the clinical experience encountered. Despite these positives, trainees stated that they would be reluctant to recommend their posts to a colleague due to the workload and the lack of opportunity to attend

	training.		
Visit team			
Lead Visitor	*Dr Catherine Bryant, Deputy Head of London Speciality School of Medicine*	**Lead Provider Representative**	*Dr Geoff Smith, Director of Imperial College Healthcare, Lead Provider*
Trust Liaison Dean	*Dr Chandi Vellodi, Trust Liaison Dean, Health Education England North West London*	**Acute Medicine External Clinician**	*Dr Nick Murch, Training Programme Director, Royal Free London NHS Foundation Trust*
Lay Member	*Lesley Cave, Lay Representative*	**Scribe**	*Rishi Athwal, Deputy Quality and Patient Safety Manager*

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement
GMC Theme 1) Learning environment and culture			
AM1.1	**Patient safety** The visit team was told that there was a 72 hour maximum stay in the acute medical unit (AMU), however there was no automatic trigger for them to be seen again by a consultant should this 72 hour limit be exceeded. Trainees reported that they would inform the consultants once they were aware that a patient had been in the AMU for over 72 hours. They also said that all patients in the AMU were discussed every day in board rounds, but they were not necessarily seen. Trainees had reported weekly incidents regarding patients being sent from the emergency department to the medical wards without anybody being aware of it. They said that there was no medical assessment completed when these patients were transferred, and that it had resulted in patients being missed. The visit team heard that the 8.30am handover was poorly attended and that there was no consistent consultant presence. It was reported that there were also rarely any trainees from other departments present. This led to patients being transferred in and out of the AMU without appropriate handover. It would also result in the trainees often spending large amounts of time trying to contact the relevant doctors throughout the day to hand patients over to. This handover was said to be trainee led. Trainees told the visit team that they did not feel that the department was unsafe, but they felt that the reason for this was that they and others were working excessive hours to ensure that it was not. They said that the department had good consultants that cared about patient safety but the	There needs to be face to face consultant review of all patients on AMU at least every 48 hours. For any patient being admitted to the AMU there needs to be a formal medical handover. The pathway for admission for acute medical patients' needs to support this process and be audited. The post-take AM consultant and GIM consultant need to be present at 8.30 am handover. Each medical specialty needs to ensure they have a representative at this handover. This process needs to be audited and monitored.	Immediate Mandatory Requirement Immediate Mandatory Requirement Immediate Mandatory Requirement

	fact that they were so short-staffed that working long hours was the only way patient safety could be ensured.		
AM1.2	**Serious incidents and professional duty of candour** Trainees told the visit team that there was a 'heads up' session in which they were able to raise any concerns that they had encountered. They reported that they were encouraged to complete datix reports by the consultants but admitted that they did not always complete these as they were so busy. The visit team was told by the trainees that they had received verbal feedback when they had raised incidents in the past. One trainee mentioned that as a result of this verbal feedback they provided further information, but that they did not hear anything further regarding the incident after providing this information. Educational and clinical supervisors told the visit team that they had used previous incidents as learning opportunities. They detailed an undermining incident from the previous year that had been used at a learning event for communication under pressure. The supervisors detailed that their 'heads up' initiative had been deemed a success and was being implemented across the Trust. It was reported that some of the concerns that would be raised in the 'heads up' meetings would be translated into datix reports if necessary. The consultants told the visit team that there was formal recognition of feedback as part of their incident reporting process.		
AM1.3	**Rotas** The visit team heard from the clinical lead and college tutor that the on call rota was drawn from all medical specialties, including acute medicine. The clinical leads detailed that they were planning to change to a rota where the consultants undertook four day blocks instead of changing each day. They hoped that this plan would enable the acute medicine trainees to work more daytime on call shifts which would enable them to have more appropriate experience. They stated that this system had worked well at Chelsea and Westminster Hospital. The visit team heard that in order to implement this new plan there would need to be between six and seven acute medicine consultants; however, there was currently 3.8 full time equivalents within the department with plans to increase this to 4.8 shortly. The feeling was that the department would have a mix of acute medicine consultants and general medical physicians who had an acute medicine interest. There was an expectation that following the change in the rota, there would be cross-site jobs in acute medicine which it was hoped would help with recruitment. It was not foreseen that trainees in any significant number would be working across the two hospitals. The clinical lead and college tutor felt that the trainees were able to have exposure to a rich and varied training experience at West Middlesex Hospital, and they felt that the trainees received good supervision. However it was noted that the trainees' workload was an issue, and that they would often stay late because of this. There was a feeling that the workload issue was improving	The department is to share the updated rota with the visit team.	Recommendation

	and that they had recently implemented a system whereby if trainees stayed late one day, they could come in late the next day. They indicated that trainees had developed their own internal rota so that they were able to attend grand round meetings. They also stated that there was an opportunity for them to have locum cover so that they could attend teaching days. The visit team heard from the college tutor and the clinical lead that the opening of the Ambulatory Emergency Care (AEC) service had been a positive development. They stated that this had a dedicated medical and nursing workforce and had been set up to relieve pressure on the acute medical take. Patients did not stay there overnight. The clinical leads also reported that an additional locum that had been introduced to the twilight shift which had been beneficial as this was the busiest time. They said this locum was being staffed through a bank of previous or current trainees. The visit team heard that a business case had been approved in the last year for three new middle grade doctors, but that they were unable to recruit to these posts. Trainees reported to the visit team that the weekend on call team consisted of a higher trainee, a core trainee and one foundation doctor. They told the visit team that this team would cover all the medical wards. The consultants would usually be there until the early afternoon, and would come back in the evening. Trainees reported that when they were on call at the weekend they would have to review all the discharges as there was no nurse-led discharging. Trainees stated that they needed to see all the patients that required discharge as well as the sick patients on the ward round, as a result of this they reported that they would usually stay late to ensure patient safety. One trainee told the visit team about one particularly busy weekend where they were seeing patients in the waiting rooms as they did not have the required bed or staff capacity. The visit team heard from the trainees that they had not been briefed on the plans to cope with the winter pressures. However they said that there was now a winter pressure locum. Trainees indicated that even with this locum, who was usually filled with trainees or former trainees that knew the hospital, there was already too much work. Trainees said that they received many emails regarding this locum shift, but said that they were not pressured into working it. They said they would often agree to work the shift as they did not want their colleagues to have a difficult experience on call. Trainees told the visit team that they had been invited to be involved in the discussions about the introduction of a new rota following the acquisition by Chelsea and Westminster Hospital NHS Foundation Trust. They reported that they currently had to work late as this was when the scan results were received, but that on the new rota they would be scheduled to work later. Trainees also said that there was a diary card exercise scheduled for December 2015. Clinical and educational supervisors told the visit team that the proposed changes to the rota should be positive; they indicated that they were currently discussing whether they should replicate the Chelsea and Westminster Hospital NHS Foundation Trust model and that they were aware that the current system was not working. The supervisors reiterated that the trainees would be involved in the process. They felt that their main concern if they moved to this rota would be	Please review this process as it is not an efficient use of the higher trainees' time on call to be reviewing the discharge of all patients on the AMU and being called to the emergency department to do the same. Please provide the results of this diary card exercise once it has been completed.	Mandatory Requirement Mandatory Requirement

	that when somebody was on call, it would leave their team short. The clinical and educational supervisors told the visit team that they had increased staffing at the weekends, stating that there was additional consultant cover on Sundays and an additional higher trainee or locum and foundation doctor on both Saturday and Sundays. They detailed that this extra cover was put in place in order cope with the winter pressures.		
AM1.4	**Handover** The visit team heard from the trainees that the Friday to Saturday handover rarely occurred and when it did there was no duty for the core trainees to attend. They felt this was necessary as they saw a lot of the patients on call at the weekend. The visit team heard that patients were discussed each day at a lunchtime meeting at this time there was a handover of any new, potentially sick patients. In addition to this the trainees also said that there was an 8.30am handover meeting every day. Following this handover meeting the visit team was told that the post-take continued from the morning; trainees indicated this would usually be concluded by midday as long as they had started at 7.30am. The trainees told the visit team that there were 45 patients on the AMU.	Ensure that the Friday to Saturday handover takes place and is a robust process. Review the attendees at this handover as part of this.	Mandatory Requirement
AM1.5	**Protected time for learning and organised educational sessions** The visit team heard from the trainees that they would take turns to go to training days. However there was concern amongst the ST3 trainees that as other trainees were approaching the end of their training, that they would not be able to attend any training when they reduced to two higher trainees in the department. The trainees said that there was support for them to get a locum in place so that they could both attend, and said that this was possible on the last training day. The trainees indicated that they were not able to go to grand rounds currently, but said that they would like the opportunity to attend them. They said that the consultants were very encouraging about them attending the grand rounds; however the workload of the job meant that they were unable to. The trainees told the visit team that they had limited opportunities to go to clinics, with one having attended three and the other not having attended any. The trainee that had been able to attend three clinics reported that they had to stay late on each occasion to make up for the time lost. The visit team heard from the educational and clinical supervisors that there was an educational fellow who provided bespoke training for both the trainees and other members of the department.	Ensure trainees are able to attend regional training days, and that there is a plan in place for the ST3 trainees when the third trainee achieves CCT. When the new rota is introduced, ensure there are opportunities for the trainees to attend grand round meetings, regional teaching, clinics and gain experience in ambulatory care unit	Mandatory Requirement Mandatory Requirement
AM1.6	**Access to simulation-based training opportunities** Consultants told the visit team that they had introduced simulation training on the ward for the junior doctors and the nursing staff.		
AM1.7	**Organisations must make sure learners are able to meet with their educational supervisor**		

	on frequent basis Some trainees indicated that they had no concerns regarding meetings with their educational supervisor and stated that they had been able to meet with them and had a learning agreement in place. Others had been able to meet with their educational supervisor but they had not been able to sign off the learning agreement because the consultant was currently still a locum appointment.	Ensure that educational supervisors for all trainees are substantive consultants within the department.	Mandatory Requirement
GMC Theme 2) Educational governance and leadership			
AM2.1	**Impact of service design on learners** Trainees told the visit team that the department was stretched in terms of staffing and workload. They felt that this was exacerbated by the fact that the consultant changed every day, meaning that the only continuity of care was provided by them. This resulted in the jobs being very ward-based and meant that they were often not able to attend clinics and training despite consultant support to attend these. Trainees reported that as there were no core trainees within acute medicine this meant that they often had to spend even more time on the ward. Trainees reported feeling like 'glorified core trainees' as they were so ward-based. Trainees reported that the fact that the consultant changed every day also meant that there were new management plans each day as each consultant worked differently. Trainees also mentioned that there were up to 10 outlying patients at any one time. The educational and clinical supervisors reported to the visit team that the department was very busy and that in the last 18 months they had seen an increase in the numbers of patients. They reported that the on call physician of the weekend covered 45 patients on the AMU and 40 patients on take. They stated that there was a need for them to ensure the standard of patient care did not fall despite being understaffed. It was reported that there would be a locum post made substantive as well as there now being two new dermatology consultant posts being recruited to that would have a split job including some time in acute medicine. Educational and clinical supervisors told the visit team that between 9am and 5pm most patients would have been seen by a consultant in the post take ward round. They said that during the 8.30am handover all patients that were seen by the consultants the night before were discussed. The visit team was told that there was a dedicated acute medicine physician that attended this handover and the consultants felt that if everyone attended that it worked. However the consultants did agree that some teams were better at attending than others, and they felt that the variability was unacceptable. Educational and clinical supervisors reported that on Monday to Friday, there was one consultant present on the AMU; they said the consultant would sometimes be called to the outlying patients. Each day there was a consultant-led board round and at 4.30pm there was a consultant-led assessment. The educational and clinical supervisors told the visit team that they did not see all the patients every day and said that the acute medicine consultant would change every one or two days. The educational and clinical supervisors indicated that they would like to move to a system		

	where there was more consistent cover on the ward but said that they currently did not have the staffing levels in place to achieve this. The educational and clinical supervisors reported that in acute medicine they had applied to get general practice trainees and core medical trainees without success. They felt that this was required for the ward as there was a large gap between the foundation doctors and the higher trainees. The consultant body felt that they would be able to support education for core level trainees. The visit team heard from the clinical and educational supervisors that there trainees would consistently come back to the hospital once they had qualified as consultants. They stated that there was only one consultant in the department that had trained elsewhere. However the consultants acknowledged that the increased workload was affecting the quality of training and education. They hoped that the acquisition would enable them to be able to resolve some of their staffing issues so that they could get the workload situation under control and offer higher quality training and continue to attract trainees back to the hospital.		
GMC Theme 4) Supporting educators			
AM4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team heard that there were currently only 1.8 full time equivalent substantive consultants in post within the department. The educational supervision was provided by two consultants who had to supervise both the three higher trainees and four foundation doctors. They felt that they did not have this reflected in their job plans.	Review the job plans for the educators within acute medicine to ensure that they have the relevant time for education within them.	Mandatory Requirement
GMC Theme 5) Developing and implementing curricula and assessments			
AM5.1	**Appropriate balance between providing services and accessing educational and training opportunities** The visit team was informed by trainees that there was no phlebotomist on one of the AAU (acute assessment unit) wards. They said that they had raised this on numerous occasions. The trainees also felt that they needed an acute geriatrician to support them, as a lot of their workload was taken up by elderly patients who they felt could be discharged earlier.	Ensure there is phlebotomy cover on all AMU wards.	Mandatory Requirement

Good Practice	Contact	Brief for Sharing	Date

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

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Catherine Bryant, Deputy Head of London Speciality School of Medicine*
Date:	*21 December 2015*