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Quality and Regulation Unit (London and South East)

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

Quality Visit Report

17 November 2015

Final Report

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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. The Trust had been visited in previous years and the high workload combined with a lack of consultants had produced the problem of a lack of clinical supervision for trainees. This was reported in the Foundation School visit that occurred in 2013 and it was felt in light of the reconfigurations, the acquisition and the results of the General Medical Council's National Training Survey results in 2015 a visit to review the training environment for foundation trainees was necessary.
Visit summary and outcomes	The visit team would like to thank the Trust for accommodating the visit and for the well-attended sessions the visit team encountered. The visit team met with thirteen foundation year one (F1) trainees in care of the elderly, orthopaedic geriatrics, urology, gastroenterology, endocrinology, general surgery, acute medicine, emergency medicine, liaison psychiatry, and community psychiatry. This was followed by a session where the visit team met with seven foundation year two (F2) trainees in, acute medicine, emergency medicine, home treatment psychiatry, gastroenterology and otolaryngology. There were also separate meetings during the day, which included the senior management meeting and the clinical and educational supervisors. The visit team found a consultant body that was very proud and committed to the training of the foundation doctors within the Trust and the consultant body worked cohesively to support trainees. There were good opportunities within the simulation programme and the work regarding the Heads Up and Leadership programmes should be commended. The visit team was also pleased to find that the new psychiatry posts for F1 doctors were working well, with an excellent balance of teaching, training, and research opportunities, which were well supported by the educators. However, the foundation trainees in psychiatry were the only trainees who were able to optimally benefit from the number of training and teaching opportunities the Trust provides. The visit team found that the consultants and senior management were all aware of the very high workload at the Trust but felt that there was a lack of comprehension on how in reality this was detrimental to the trainees' training and educational experience at the Trust. The high workload was prohibiting trainees from accessing regular departmental teaching, meetings and performing procedures. The visit team appreciated that there was an increase of patients due to the reconfiguration of services in North West London through Shaping a Healthier Future; however this is exacerbated through the lack of consultants, middle grade doctors and health care professionals at the West Middlesex University Hospital site. This had resulted in trainees undertaking inappropriate tasks but more concerning was the lack of clinical supervision that many foundation trainees encountered regularly. The handover system was found to be ineffective with patients being lost or found to be the responsibility of departments on quite a regular occasion. There was also a lack of clarity for patient movement around the different medical wards and the movement of patients to the escalation ward too. There was also found to be a lack of clarity around the processes for requesting and cancelling scans, which had caused delays in patient care. The visit team found a Trust that, although having the ability to provide excellent training and education to trainees in Foundation, the lack of clarity around systems, the lack of clinical supervision and the very high workload inhibited trainees' ability to optimise the Trust's educational potential. However, the majority of foundation trainees would recommend the foundation posts at the Trust for training.

Visit team			
Lead Visitor	*Dr Anthea Parry, Deputy Director of North West Thames Foundation School*	**External Representative**	*Mr Turshar Agarwal, Consultant General & Colorectal Surgeon, London North West Healthcare NHS Trust*
Trust Liaison Dean	*Dr Chandi Vellodi, Trust Liaison Dean, Health Education England North West London*	**Foundation School Representative**	*Philippa Shallard, Foundation School Manager, North West Thames Foundation School*
Lay Member	*Jane Gregory, Lay Representative*	**Observer**	*Dr Benjamin Norton, Year 1 Foundation Doctor*
Visit Officer	*Lizzie Cannon, Quality and Visits Officer*		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement
GMC Theme 1) Learning environment and culture			
F1.1	**Patient safety** The visit team heard that in gastroenterology, endocrinology, and respiratory when there were no consultants on the wards there was supposed to be a higher-grade trainee or equivalent trust-grade doctor present. However, this did not occur on Wednesdays because of multi-disciplinary team (MDT) meeting the higher-grade doctors attended. On occasions, this had happened on Friday afternoons, which meant that patients did not receive good weekend management plans. The visit team heard from the foundation trainees that a consultant, at some point in the patient pathway, normally post-take, saw all patients but after this, higher or middle-grade doctors saw patients. The foundation trainees stated that patients could be discussed at board and ward rounds, however the consultant would only see the patient if the foundation trainee had concerns. The visit team heard that patients could be discharged without a senior review. This occurred on the medical wards and acute medical unit (AMU). The F1 trainees on the AMU stated that they did try to get a senior review before the patient was discharged and F2 trainees confirmed that all patients had a senior review before being discharged. The F1 trainees stated that they had not technically lost patients but they had found patients by chance on other wards before because the trainees had happened to be on the ward. The trainees stated that this occurred on the Syon Ward frequently because this was a mix of both surgical and medical patients. The nurses would triage the patients but not put them under the care of a medical team on real-time. This had resulted in patients not being seen for days by the	The Trust is required to ensure that all patients are reviewed by a senior and competent clinician beyond the post-take and before the patient is discharged. The Trust is required to review how medical and surgical patients are triaged on the mixed wards and ensure that the medical teams are aware of all patients in outlier wards, including any	Mandatory Requirement Mandatory Requirement

	medical teams. The trainees stated that they had to go to the mixed surgical and medical wards and check the boards to see if any new patients had been admitted, however the trainees stated that the boards could frequently be wrong too. The F2 trainees stated that this was also the case on the AMU, with no formal system of handover for patients admitted to the ward and only occasionally, would there be a verbal handover. The F2 trainees stated that the Marble Hill Two Ward had opened in the first week of November 2015 to ameliorate the winter pressures. The trainees stated that the patient numbers were variable and patients from AMU were moved to the Marble Hill Two Ward. The trainees stated that the ward was staffed by agency and some Trust nursing staff, but it was too early to gauge the quality of staff that covered the ward. The F2 trainees stated that they had patient safety concerns regarding the ward because there was no mechanism for identifying which team was responsible for which patient or when patients were moved from AMU to the ward. The trainees stated that they reported the concerns and the ward was zoned to identify which patients belonged to which department, however there had not been an improvement in the mechanism for communicating when these patients arrived in the Marble Hill Two Ward. The F1 trainees stated the West Middlesex University Hospital site was not safe for patients on the weekends and that a lot of the time patients had to wait to be transferred to the Chelsea and Westminster Hospital, because the West Middlesex University Hospital site did not offer certain treatments to patients. The F2 trainees stated that the emergency department was good with a highly competent nursing body and they would be happy for friends and family to be treated in the emergency medicine department. However, the F2 trainees did have concerns regarding the systems used to move around the hospital and the resultant lack of communication and clarity.	escalation wards. This should form part of a review into a more robust handover system.	
F1.2	**Serious incidents and professional duty of candour** All the trainees stated that they were encouraged regularly to complete serious incident (SI) forms through Datix and the trainees received an email containing feedback. The trainees stated that the SIs were gathered by a higher training grade and then if there was anything more serious this would be escalated to the consultants. The visit team heard that the psychiatry trainees were not given feedback when they submitted SIs because this was done through the West London Mental NHS Foundation Trust. The trainees did state however that they had been fully supported and debriefed when there was direct trainee involvement in SIs. The visit team was concerned to hear that the F1 trainees were unaware of the location of the whistle blowing policy and this was not covered in the induction.		
F1.3	**Appropriate level of clinical supervision** The visit team heard from the senior management team and the consultants responsible for foundation training that there was a recruitment drive for healthcare professionals, especially nursing staff and that the retention rates had increased because of this. However, the consultants		

	did state that they were aware that the workload was still very high for trainees and there were low consultant numbers in many specialties which had been highlighted through the merger. The urology department was reported to have a small team, which allowed for one F1 doctor, a middle grade trainee or equivalent trust grade doctor and a higher trainee or equivalent trust grade doctor to be present on the wards. The urology consultants were reported to do only list and were not present on the wards or carry out ward rounds. This led the department to be run by the higher grade doctor but the trainees reported that the higher grade, although was on site, could still be inaccessible to the foundation trainees because the registrar would frequently be called down to the emergency department. The visit team heard that if there was a problem with a patient and the higher-grade doctor was unavailable the foundation trainee would have to find a consultant or a general surgery consultant in theatre or on call. However, this was not always possible and the trainee would be left to cope with the patient alone. The F1 trainees in respiratory stated that due to the rota and limited number of doctors there could be only two F1s responsible for the outlier patients and respiratory ward, this could amount to 30 patients. The F2 trainees clarified that there were 50 patients including outliers that were the responsibility of the AMU. The trainees stated that the patients on assisted ventilation were scattered amongst the other patients on the ward. If the settings for the assisted ventilation patients needed adjusting the trainees needed to contact a senior colleague or a critical care outreach nurse, however they were not always available. The visit team was concerned to hear that there was no robust plan, which outlined when consultants would see patients and the trainees were not aware of whom to escalate patients to, because it was difficult to know which consultants would be on the rota. The trainees stated that the respiratory higher training grade or equivalent trust-grade doctor would see acutely unwell patients while on call. During the day the endocrinology higher-grade trainee or equivalent trust-grade doctor would cross cover the respiratory and endocrinology patients and was there to give advice to the trainees. It was reported that the two consultant ward rounds per week and twice a week higher-grade trainee ward rounds which should have occurred were intermittent. The respiratory and endocrinology patients shared the same ward and the visit team heard that there were also poor levels of clinical supervision for F1 trainees in endocrinology. The trainees reported feeling quite unsupported because there was a lack of consultant or higher-grade trainees or equivalent trust-grade doctors' presence on the ward as the rota put the consultants predominantly on nights. The trainees did report however that the core trainees received acute medicine exposure through on calls and not through a two-month placement. The foundation trainees appreciated this because it allowed for some continuity with senior clinical support. The F1 trainees in emergency medicine stated that the middle-grade doctors in the emergency department were excellent, as was the higher-grade trainee who was responsible for running the department. However, when the department was running at capacity the F1 trainees stated that it was not always possible to ensure a senior review of the patient. The F1 trainees stated that the consultants in emergency medicine all had other commitments and were not always on the shop floor. The trainees also stated that because there were only six whole time equivalent (WTE)	The levels of clinical supervision were inadequate within the urology department. The Trust is required to ensure that consultants are doing regular ward rounds during Monday to Friday and that there are adequate levels of clinical supervision throughout the week. Senior clinical support must be available and accessible to foundation trainees at all times. The levels of clinical supervision were inadequate for foundation trainees in respiratory. The Trust is required to ensure that respiratory consultants are doing regular ward rounds during Monday to Friday and that there are adequate levels of clinical supervision throughout the week. Senior clinical support must be available and accessible to foundation trainees at all times. The levels of clinical supervision were inadequate for foundation trainees in endocrinology. The Trust is required to ensure that endocrinology consultants are doing regular ward rounds during Monday to Friday and that there are adequate levels of clinical supervision throughout the week. Senior clinical support must be available and accessible to foundation trainees at all times.	Mandatory Requirement Mandatory Requirement Mandatory Requirement

	substantive consultants in the emergency department if there were four code blues and some acutely unwell patients all the consultants and higher-grade doctors would be unavailable to support the foundation trainees. The Specialty-Focused Visit for emergency medicine which occurred immediately after the foundation Specialty-Focused Visit corroborated that the consultants were frequently absent from the shop floor. The visit team also heard from the F2 trainees that in the daytime the trainees could find a consultant until either 5pm or 7pm. However, out of hours the consultants were only available by phone and although the high-grade doctor supervised the shop floor at night, they were not always available to review patients because of the high workload. The F2 trainees stated that there was no robust support at night for trainees in the emergency department, because of the lack of staff and the high workload. The F1 trainees in gastroenterology stated that when the higher trainees attended training days on occasional Fridays and the consultants were in clinics the F1 trainees were left alone, without any clinical supervision. The visit team heard that an F1 carried out a chest drain with no clinical supervision; this is a patient safety concern. The F2 trainees stated that there was not always clinical supervision and senior support was not always available because the higher-grades were very busy and did not always answer the phone. The F1 trainees in the other specialties the visit team met, stated that they were aware of who to escalate acutely unwell patients to out of hours and foundation trainees in medical specialties were given a print out with all of the bleep numbers.	The Trust is required to ensure that adequate levels of clinical supervision are maintained for foundation trainees working within the emergency department. The Trust is required to ensure that adequate levels of clinical supervision are maintained for foundation trainees working within gastroenterology.	Mandatory Requirement Mandatory Requirement
F1.4	**Responsibilities for patient care appropriate for stage of education and training** The visit team heard that none of the foundation trainees had prescribed cytotoxics or had site marked a patient for surgery. All the F2 trainees stated that none had performed tasks outside of the competencies. The F1 trainees reported that the availability of phlebotomists was variable to non-existent depending on the ward. The Richmond Surgical Ward and the AMU reportedly had no phlebotomists and nurses did not fulfil this role. On the gastroenterology ward it was reported that the phlebotomist could do up to seven bloods in the morning, this meant the phlebotomist picked patients at random. The lack of phlebotomists across the Trust meant that F1 trainees were routinely undertaking phlebotomy and this was detrimental to the number of other training opportunities they could access.	The Trust is required to ensure that FY1 trainees' workload does not impede the accessibility of training opportunities and the trainees are not constantly undertaking phlebotomy or other inappropriate roles. It is recommended that the Trust recruit more phlebotomists, especially in wards which have none.	Mandatory Requirement
F1.5	**Taking consent** The foundation trainees had been asked on occasion to take consent, however they had explained to the requester that this was beyond the role of a foundation doctor and this had been understood. This was confirmed by both F1 and F2 trainees.		
F1.6	**Rotas** The visit team heard from the F1 trainees that the workload was exceptionally high in all		

	departments, except for the two psychiatry posts where the workload came in peaks and troughs, with one F1 in liaison psychiatry stating that if the ward patients were fine and there were no clinics, there would be very little to do for an afternoon. The F1 trainees in AMU stated that the workload was intense because there were 40 beds and several outlier patients that the trainees were responsible for. The trainees in care of the elderly also stated that due to the number of patients and lack of staff there was a very high workload. The other F1 trainees stated that they commonly left late and were unsure if they were compliant with the European Working Time Directive (EWTD). The F2 trainees in all specialities the visit team met with stated that workload was very high and the number of hours the trainees worked depended on the workload of the day. The F2 trainees in gastroenterology stated that the average time the trainees left was 7pm and the latest it had been was 11pm. The visit team was pleased to hear that both the F1 and F2 trainees were to undergo a diary card monitoring exercise to review how EWTD compliant the rotas were.	The Trust is required to provide the results of the diary card exercise for all the foundation trainees and ensure that all trainees are working within the EWTD.	Mandatory Requirement
F1.7	**Induction** The Trust induction was reported to be fine by the F1 trainees, however there was an inconsistency in the quality of local, departmental inductions for F1 trainees. The F1 trainees in urology stated that there was no official induction and the trainees had started without one. AMU local inductions were supposed to last for four days but the F1 trainees reported that the induction only lasted two days and it would be appreciated if the Friday handover could be incorporated into the induction too. Other F1 trainees stated that the local inductions were adequate. The F2 trainees reported that they would have appreciated a more detailed Trust induction with information regarding the protocols and systems for out of hours, referrals and on calls. The F2 trainees also stated that they would like local process covered in the departmental induction. Some F2 trainees had started without local inductions and on nights, such as in gastroenterology. The F2 trainees in acute medicine stated that they had an induction but this was six weeks into the trainees' placements.	The Trust is required to review and improve the local inductions for F1 and F2 trainees and ensure this is delivered within a week of starting the placement. This is especially pertinent in urology and AMU.	Mandatory Requirement
F1.8	**Handover** The visit team heard from both the F1 and F2 trainees that the handover in medicine occurred at 8.30am every day between the day and night teams on the AMU. This was supposed to be attended by a representative from each medical team and the post-take consultant was supposed to attend. However, the presence of the post-take consultant was variable depending on the individual consultant with attendance being averaged at three-fifths of the handovers. The higher-grade doctors would also tend to skip the handover because it clashed with ward rounds. The trainees in the medical specialties other than AMU did state that the majority of the handover was felt to not be relevant for the medical specialties because the handover mainly consisted of the	The handover system is inadequate. The Trust is required to review the morning handover and weekend handover. The review should look at optimising attendance and efficiency of the handover. The Trust should look at the structure of the handover and the processes within the handover to allow for a better handover system.	Mandatory Requirement

	AMU night team handing over patients to the AMU day team. The trainees stated that they would appreciate if the specialties could come at the end of handover for efficiency. The trainees reported that because the medical teams did not attend the morning handover the trainees used real-time, the electronic patient record system that catalogues all the patients on the different wards. The middle-grade doctor on the previous night shift would also come round and find the relevant trainee to inform them of a new patient, but this depended on who the middle-grade doctor was. There was no formal process. The F2 trainees confirmed that there was no formal handover of patients to the hospital at night team. The site manager, middle-grade doctor, higher-grade doctor and higher grade surgeon were supposed to attend a meeting to handover the patients for the night, however the trainees stated that there was only attendance if they had concerns about patients. The trainees stated that all patients were logged in the real-time system, but this was not infallible. The F1 and F2 trainees reported that the handover at the weekend occurred at 4pm on a Friday. The handover involved all medical teams inputting onto real-time the patients that need to be reviewed and the jobs, such as bloods, that need to be ordered and done over the weekend. There was also supposed to be a higher-grade trainee or locum doctor that would be present to verbally handover all information to, however the trainees stated that this did not always occur. The trainees described the real-time system as useless, this was because it would regularly delete or miss off patients that were inputted for the weekend handover. The foundation trainees stated that they did not think any patients came to harm because of the inefficiencies of the handover system, but they stated it would be hard to find out. The trainees stated that to cover the inadequacy they would bleep the higher-grade doctor on call on the Friday and ask them to go and check on the patients the trainees were most concerned about. The foundation trainees in the emergency department stated that the shifts were staggered which meant that there was no formal handover at one set time. The trainees stated that doctors handed over patients to the incoming doctors verbally.		
F1.9	**Protected time for learning and organised educational sessions** The F1 trainees in endocrinology stated that the workload did not always allow for trainees to attend or even facilitate the time for local teaching to occur. The F1 trainees in gastroenterology also stated inconsistent departmental teaching. The teaching, when it did occur in gastroenterology was not led by seniors although the consultants were present. The F1 trainees in gastroenterology stated that the teaching occurred in conjunction with the departmental meeting which was attended by all staff, in the department. The F1 trainees stated that there was a grand ward round for medicine held on Tuesdays but the trainees' workload prohibited attendance. The F1 trainees in the emergency department stated that there was departmental teaching. As did	The Trust is required to ensure and provide evidence that F1 and F2 trainees are receiving regular departmental teaching in all placements.	Mandatory Requirement

	the F1 trainees in care of the elderly, which was in the form of a journal club held every Monday. The F1 trainees in psychiatry stated that there was always good teaching all day on Wednesdays. Orthopaedic-geriatrics was also reported to have good, daily teaching which was incorporated into the daily departmental meeting. The F1 trainees the visit team met, all confirmed that there had been no problems encountered when being released for F1 teaching. The F2 trainees in emergency medicine stated that it was nearly impossible to attend F2 teaching sessions. The F2 trainees in emergency medicine also stated that the departmental teaching occurred at 4pm, which meant that frequently they could not attend because the shifts started before 4pm. The F2 trainees in psychiatry stated that there was good teaching on Wednesday afternoons with a specialty talk and clinical supervision afterwards. The visit team heard that 50 per cent for F2 trainees in gastroenterology were able to attend departmental, weekly teaching. The consultants in AMU reported that there was a multi-disciplinary team (MDT) meeting that was held every day and the trainees were invited to attend these meetings, where free conversation and discussions were encouraged. The consultants also stated that there was in situ simulation teaching that occurred in the AMU which was followed by a debrief. However, the F2 trainees in AMU stated that there was teaching on Wednesday lunchtimes and then skills teaching on a Friday, however because of the high workload trainees could not attend very often.		
GMC Theme 2) Educational governance and leadership			
F2.1	**Impact of service design on learners** The visit team heard from the senior management meeting that the acquisition meant that the training opportunities for trainees at both hospitals could be increased. The visit team heard that there was the potential to develop internal rotations and the use of both sites simulation centres which offered excellent and different approaches to learning. The use of internal rotations was also stated to be an option for improving staff retention rates and as such improve the intransigent concern of the inequitable ratio of workload to workforce. The visit team heard that a larger Trust and the move to divisional units would help improve recruitment rates of all staff, especially consultants. The idea of cross-site working was also stated. The visit team heard from the consultants that cross site working would be welcomed to ease the inequity of consultant between the two sites, to improve clinical supervision and service. The reorganisation of services within North West London through Shaping a Healthier Future (SaHF) it was reported had already brought an increase in workload due to the movement of maternity cases which the visit team heard had been well planned and had been managed well. However the trust had started to see the increase in paediatric cases too and this had not been		

	well planned and there were concerns at the bed capacity in the hospital not being able to meet demand, especially over the winter. The senior management stated that there were concerns that change in services through SaHF was not being similarly transposed on to the redistribution of training posts. The consultant body was concerned that this would increase the workload even more and more trainees were needed. It must be recognised however that trainees are not to be used predominantly for service provision and the Trust should look at expanding the work force of other healthcare professionals and the consultant body, along with the opportunities of cross site working to address the increase in patient cases.	The Trust should look at appropriate redistribution of trainees across both the Chelsea and Westminster Hospital and West Middlesex University Hospital sites according to workload and educational opportunities.	Recommendation
F2.2	**Appropriate system for raising concerns about education and training within the organisation** The consultant body reported that there was a project called Heads Up which was trainee led which provided a forum for trainees to raise issues regarding wards and then implement changes on day to day working. The visit team heard that there were other conduits for trainees to feedback including local faculty groups for each specialty and the meetings between trainees and educational supervisors. The consultants stated that because of the small size of the consultant body and the close working relationships within the Trust, lots of information was shared regarding training and how to support trainees.		
GMC Theme 3) Supporting learners			
F3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The F1 trainees stated that they had certainly been harassed by patients and family in the emergency department. This was most prevalent in the observation bay where the patients did not need to be admitted and the trainees are then shouted at by the patients' family and friends because the trainee did not admit the patient. The foundation trainees stated that the senior staff were supportive regarding this and the trainees felt able to escalate if need be. The F1 trainees stated that there were sometimes problems with the staff in the radiology department. The trainees stated that they actively avoided one radiologist because of the unacceptable and unprofessional behaviour, but the trainees would still request scans for patients from this radiologist if needed. The trainees stated that some of the radiologists would not accept requested scans from the trainees as the foundation trainees were deemed too junior. The visit team heard that this was a known and historical problem with the radiologist and had been raised with the consultants. The consultants had told the trainees to document the behaviour so that proper escalation could be implemented. The F2 trainees confirmed the same problems with the radiology department and also stated that the process for ordering scans was complicated and obtuse which resulted in delays. The F2	The Trust is required to review the bullying and undermining behaviours that are on-going within the radiology department. External support can be offered through the Professional Development Unit in Health Education England. The Trust is required to review the process for requesting and cancelling scans and	Mandatory Requirement Mandatory Requirement

	trainees also stated that there was no process for informing staff if the scans ordered had been cancelled, the trainees stated that 50 per cent of cancelled were not communicated to the requester. The trainees stated that although patient safety was not in danger there were definitely delays to patient care.	ultrasounds from the radiology department. The system must ensure that scans are ordered and carried out efficiently and that any cancellations are communicated effectively to the respective staff.	
F3.2	**Academic opportunities** The visit team heard from the consultants that there was a leadership for foundation course that was run every year free of charge. This included the chance to produce a quality improvement project (QIP) and then present it to the Chief Executive Officer (CEO) and win prizes. The consultants stated that the calibre of work produced was extremely high and that there was a drive not only from the consultants but by the CEO to ensure trainees were involved and empowered to make changes in the Trust. Dr Cheema should be acknowledged for leading on this excellent course. However, the visit team heard that the workload of the trainees did not necessarily allow any involvement with QIPs. The F1 trainees stated that they had very little time to complete the e-Portfolio let alone complete QIPs. The only F1 trainees whose workload allowed time for QIPs were those in psychiatry. The F1 trainees stated that the workload was very high and those F1 trainees in care of the elderly would appreciate more time to be able to teach the third year medical students who came into the department. The F2 trainee reported that there were opportunities for QIPs but the trainees had to be proactive.		
GMC Theme 4) Supporting educators			
F4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team heard from the educational and clinical supervisors that the job planning was not equitable across the consultant body and did not take into account the impact of a high workload on the consultants' ability to perform educational responsibilities in reality. The consultant stated that as part of the integration in the acquisition all the consultants were being job planned and the consultants would appreciate having specific educational programmed activities (EPAs) configured into the job plan.	It is recommended that the EPAs be configured into educational supervisors job plans to allow adequate time for educational responsibilities.	Recommendation
GMC Theme 5) Developing and implementing curricula and assessments			
F5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team heard from the educational and clinical supervisors that because of the high number of patients there was plethora of training opportunities, with a very good case mix. The		

	consultants were aware that the high workload could be detrimental to the training opportunities available to the trainees but that the consultant body worked hard to limit this effect. The consultants in care of elderly stated that there had been attempts to ameliorate this with discharge coordinators being reemployed on the wards, clinical fellows to support the escalation ward and the use of allied health professionals. The visit team heard that the majority of F1 trainees stated that the workload inhibited the trainees' ability to optimise the training opportunities available within the Trust. With some F1 trainees stating that the post was, for the majority of the time, just service provision. F1 trainees in gastroenterology and endocrinology stated that there was little time to perform practical procedures. The F1 trainees confirmed that they were able to complete the workplace-based assessments (WPBAs) and the Team Assessment of Behaviour (TABs). The F1 trainees in liaison psychiatry reported that trainees were able to complete curriculum competencies and the workload allowed them to maximise the training opportunities available, even if workload could sometimes be very low. The visit team heard that the F1 psychiatry posts did not provide on call experience and some of the F1 trainees had become locums to gain this experience. All F1 trainees except for those in respiratory medicine would recommend the post for training. The F2 trainees in emergency medicine, gastroenterology, psychiatry and acute medicine stated that despite the high workload there was still time to complete WPBAs.		
F5.2	**Regular, useful meetings with clinical and educational supervisors** The F1 trainees in psychiatry stated that there were weekly one to one meetings with the educational supervisors and trainees. The other F1 trainees and F2 trainees stated that they had met with the assigned educational supervisor.		

Good Practice	Contact	Brief for Sharing	Date
The Heads Up project which provided a forum for trainees to raise issues regarding wards and then implement changes on day to day working			

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 Anthea Parry, Deputy Director of North West Thames Foundation School*
Date:	*21 December 2015*