Health Education England

Developing people for health and healthcare

Quality and Regulation Unit (London and South East)

Chelsea and Westminster Hospital NHS Foundation Trust
West Middlesex University Hospital
Gastroenterology
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 fitted into the realigned services was necessary. This was especially relevant with the increase in patient numbers due to the reconfiguration of services in North West London under Shaping a Healthier Future. In the 2015 General Medical Council's National Training Survey (GMC NTS) gastroenterology at West Middlesex Hospital received two red outliers and three pink outliers. The red outliers were in 'adequate experience' and 'local teaching'. The pink outliers were in 'overall satisfaction' 'access to educational resources' and 'feedback'. The results in the 2015 survey were also poor, and 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 clinical director, college tutor and training programme director (TPD) for gastroenterology at West Middlesex Hospital before meeting with the higher trainees across the specialty. Following this, the visit team met with the clinical and educational supervisors before providing feedback to the Trust. The clinical director, college tutor, and TPD outlined that in the last two years, 2013 - 2015 the GMC NTS results had not been as good as the Trust would have liked. However, they reported that they had developed an action plan based on both the GMC NTS results and conversations the consultant body and the director of medical education (DME) had with the trainees. Details of this were provided to the visit team prior to the visit in November 2015. The visit team were pleased to find from the conversations throughout the visit that there was a group of very supportive consultants who were engaged in the training and education process. The visit team also felt that the opportunity for trainees to discuss patients with the consultants after clinic lists was good practice. Consultant led teaching during multidisciplinary team meetings (MDTs) was very good and the clinical leadership and management opportunities on offer to senior trainees was to be commended. However, the visit team noted the following areas of concern. There were still concerns about the on call medicine rota, with trainees reporting that the medical higher trainee on call had to see every patient in medicine who were being discharged at the weekend. This was in addition to reviewing and discharging patients in the emergency department (patients who were not having a senior review within the emergency department (ED) which may have prevented referral to the medical higher trainee). There was still tension in ensuring that trainees had appropriate access to endoscopy clinics. The visit team suggested that the process for gastroenterology inpatient reviews by the higher trainees needed to be reviewed as trainees reported this was contributing to the trainees completing a lot of administration out of normal working hours. The visit team heard from all the trainees that they would be happy for their friends and family to be treated within the department; however, they did mention that they felt the acute medicine take was too busy. They also all mentioned that they would recommend the post for training because of the teaching and consultant support; but offered the caveat that they would like better access to endoscopy 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 North West London*	**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			
G1.1	**Patient Safety** The trainees stated that some post-take ward rounds would start early, but that others would not start until 8.30am. They said that there were often many patients remaining that trainees needed to review post take from overnight. Trainees felt that patients were 'probably not' being seen within 12 hours of admission. They reported that the majority of the time patients that had been admitted on the acute take during the day were not being seen post take by the gastroenterology consultant until the morning afterwards.	The Trust must address the inconsistent post take ward round start times (and how this is organised with morning handover) and the issue of patients admitted on the acute take not being seen by a consultant within 12 hours of admission.	Mandatory Requirement
G1.1	**Serious incidents and professional duty of candour** The visit team heard from the trainees that they were aware of datix for serious incident reporting and how to use it. Trainees reported that they received good feedback when they had reported incidents in the past.		
G1.2	**Rotas** The trainees stated that if they were working on-call overnight they would usually leave at approximately 10.30am, with their next shift starting at 9pm. They reported that the introduction of the twilight locum was very good, but that it had only been filled 50 per cent of the time to date. The visit team heard that there were issues with higher trainees having to review all possible discharges in medicine over the weekend and additionally seeing large volumes of emergency department (ED) referrals for discharge, in absence of a senior ED review. The visit team heard from the educational and clinical supervisors that the consultants were looking to move to a physician of the week model, indicating that they would work a four-day block from Monday to Thursday. The consultants felt that the result of this would be that there would be a stronger consultant presence at the post take process and would lead to them picking up referrals on a more frequent basis. They felt that this would in turn reduce the trainee referral workload. The visit team heard that the consultants' expectations were that the department would move to this model within the next four to six months, but commented that if this model would not	The department is to share the updated rota with the visit team. 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 in medicine and being called to the emergency department to do the same.	Recommendation Mandatory Requirement

	adequately improve training opportunities for trainees it would not be implemented. The consultants reported that the department had recruited a full time inflammatory bowel disease (IBD) nurse that they hoped would take away some of the workload pressures for the trainees. The consultants stated that that there was a need for the better organisation of care of the elderly as there was only a small team that dealt with this. The consultants reported that there were two consultant vacancies in care of the elderly to fill, after the appointment of a substantive consultant post following attempts to recruit to three. The visit team heard from the consultants that many of the gastroenterology patients the consultants saw had geriatric conditions, and they felt a geriatric consultant could treat them. Clinical and educational supervisors also indicated that there was funding in place for three acute medicine consultants.		
G1.3	**Induction** The clinical director and college tutor told the visit team that they had worked on the induction process since it received a red outlier in the last GMC NTS. They stated that it had been improved in the last year, and that all trainees would now have the job explained to them in detail on their first day.		
G1.4	**Handover** The visit team heard from the trainees that they would attend the 8.30am handover when they were on call. They stated that the idea was that a different representative from each specialty would attend however, it was usually the junior trainees in attendance. The visit team heard that trainees got very little from these handovers, as trainees did not find out which patients had been transferred to each ward. Trainees indicated that consultant presence had helped with the attendance at this handover, but trainees would often find out where the patients were from the ward sister.	There needs to be a consultant led handover with a representative from each medical specialty at the 8.30am handover. This process needs to be audited and monitored.	Mandatory Requirement
G1.5	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The clinical lead and college tutor informed the visit team that they felt the trainees received a good general medical experience. They stated that there were some issues that they believed may have led to the department receiving a red outlier for ‘adequate experience’ in the last GMC NTS. The visit team heard that there were issues with the movement of trainees between wards, but this had improved as the gastroenterology patients were more centralised in one area rather than being distributed over the hospital. The clinical lead and college tutor indicated that they had introduced a teaching session on Thursday lunchtime, morbidity and mortality meetings and stated that during the multidisciplinary team meeting (MDT) consultants had been present to explain things in order to make them more educational. In addition the visit team heard that there was a didactic teaching session that was consultant and higher trainee-led, and that this was introduced as a response to trainee feedback. The clinical and educational supervisors felt the endoscopy numbers the trainees received were good, but said that sometimes trainees felt they would get higher numbers at a district general hospital.		

	The clinical lead and college tutor stated that they felt that there was a need to work flexibly in order for the trainees to get the best out of their training experience. They said that they had received feedback from trainees in the past that suggested trainees would have liked their timetables to be more structured. The visit team heard that the clinical lead and college tutor had started calling the trainees asking them to attend lists if there were no other trainees in attendance. Gastroenterology trainees told the visit team that there was no allocated time in the day to see referrals, and they stated that they had to see a large amount in the day. The trainees indicated that this took up a large amount of time and as a result, the endoscopy training was a lesser priority.	There must be a review of the way that referrals are conducted, as this currently constitutes a high proportion of the trainees' workload.	Mandatory Requirement
G1.6	**Protected time for learning and organised educational sessions** The gastroenterology trainees informed the visit team that they had a morning of meetings, which included an MDT and a morbidity and mortality meeting. They stated that they also attended consultant ward rounds, as well as trainees' own ward rounds. The trainees informed the visit team that it was difficult to attend the two, timetabled endoscopy sessions per week. The trainees stated that they had raised this within the department, and felt that the consultants were working with them to try to find a solution to the problem, but the trainees perceived a solution to be difficult to find. Trainees told the visit team that they could attend any other endoscopy sessions during the week, but stated that it was often difficult to attend due to clinical commitments. Trainees felt that one way to resolve this issue could be to limit clinic numbers per trainee to two, not three per week because this time could be allocated for endoscopy lists. The visit team heard that when the trainees were able to attend the endoscopy training, it was of a very high quality. They stated that the consultants who taught were very good. Clinical and educational supervisors reported to the visit team that they may need to be more proactive about ensuring trainees are able to attend the endoscopy training as some trainee found it difficult to leave the wards. The consultants reported that it could be that the pressure of supporting the juniors on the ward and the ward referrals were a contributing factor to them not being able to leave the ward. The consultants indicated that they had tried to develop a timetable where there was specified time on most days to complete ward referrals in order to free up time for the trainees. The clinical and educational supervisors told the visit team that they felt the trainees received good training and had received good feedback from the Tuesday liver clinics, especially as they would go through all the patients with the trainees at the end. However, the consultants did say that in the past more experienced higher trainees had felt that the job did not fulfil the trainees' educational needs. The consultants indicated that this was because the hospital did not have this experience available. The consultants stated that the job was a popular one and therefore the department usually received trainees that had nominated West Middlesex Hospital as first choice. The consultants stated that the trainee mix was best when they had a combination of junior and	There is a need for trainees to have better access to endoscopy training. Please formulate a plan detailing how you will improve access to this.	Mandatory Requirement

	senior trainees.		
GMC Theme 2) Educational governance and leadership			
G2.1	**Impact of service design on learners** Trainees informed the visit team that they would have an average of 44 inpatients, but this could increase to 55. The trainees stated that there were two foundation year two trainees (F2), one core trainee, and a higher trainee on each team. There was support from a phlebotomist and an IBD nurse. Some trainees indicated that they would often start early because there was no administrative support for clinics or any time allocated for this.	The department is to review the trainees' weekly timetables to ensure time is provided for administrative and inpatient review activity.	Mandatory Requirement
GMC Theme 3) Supporting learners			
G3.1	**Academic opportunities** The visit team heard from the gastroenterology clinical lead and college tutor that there were good academic opportunities available to the trainees and they indicated that there had regularly been trainees presenting nationally and internationally as well as writing peer reviewed papers. In addition to this there was a lot of management experience on offer, and they reported that trainees had often used the job as a stepping stone into a management focused role such as becoming educational or Darzi fellows.		
GMC Theme 4) Supporting educators			
G4.1	**Sufficient time in educators' job plans to meet educational responsibilities** Clinical and educational supervisors told the visit team that most of them were on a 2.5 supporting professional activities (SPA) contract, though they were unsure of how much of this was allocated for educational time. The consultants felt that this was an adequate amount of time for them to have allocated to training, but did not feel that they were in reality provided with this amount of time in their working weeks. They felt that the Trust was unable to recognise which consultants were responsible for a lot of training and which were not. The educational and clinical supervisors felt there could be a more equitable distribution of the programmed activities (PA) amongst the consultant body. The clinical lead and college tutor reported to the visit team that they felt there was a need for clinical and educational supervisors to have sufficient time in their job plans to be able to deliver good educational and training. They said that this would be under review following the acquisition by Chelsea and Westminster Hospital NHS Foundation Trust, but felt that it would not be a problem for the educators to demonstrate that they require the necessary PA in their job plans.		

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*