Health Education England

HEE Quality Interventions Review Report

The Hillingdon Hospitals NHS Foundation Trust (Hillingdon Hospital)
Medicine (AMU)
Learner and Educator review

London – North West London
Date of Review/Intervention: 19 May 2022
Date of Final Report: 8 July 2022

Review Overview

Background to the review

This review was a follow up risk-based (learner and educator review) following a number of reviews, the most recent being a learner and educator review that took place in November 2021. In August 2019 foundation posts were relocated within the Trust due to concerns around the level of support in the Acute Medical Unit (AMU). Following continued concerns in December 2019 it was confirmed that a higher trainee had been removed from the department by the Speciality School. A risk-based (learner and educator review) took place in May 2021; the purpose of the visit was to review progress and discuss how the acute medical unit would support IMT3 trainees from August 2021. It was agreed that IMT3 trainees could be placed within the department from August 2021. Due to ongoing concerns the review team requested for a follow-up learner and educator review to take place in November 2021 to review progress made.

A risk-based (learner and educator review) took place in November 2021, the purpose of the visit was to review progress against ongoing concerns. The review panel noted a number of concerns including issues with supervision, and a difference in perceptions between consultants and junior doctors about workload and the value of and process for exception reports. Concerns about lack of pastoral support and reports of bullying and undermining were also noted. Given the ongoing concerns the ISF rating was increased to ISF3, and a follow up risk-based review was requested. The GMC was involved in this review as the department had been under enhanced monitoring since March 2022.

Subject of the review:

Medicine- Acute Medical Unit (AMU)

Who we met with

5 Clinical and Educational Supervisors
13 postgraduate doctors in training working in the department from the following programmes: Foundation Programme, Internal Medicine Training (IMT), and Specialty Higher Training.
Director of Medical Education
Medical Education Manager
Deputy Medical Education Manager
Clinical Director of Unplanned Care
Education Lead and College Tutor for Medicine
Guardian of Safe Working Hours
Medical Director
Chief People Officer

Evidence utilised

Medicine Local Faculty Group (LFG) Minutes- February 2022, March 2022 and April 2022
Action Plan Log and Progress Report

Acute Medicine Unit (AMU) Datix Incidents Report
AMU Exception Reporting History
AMU Fortnightly Survey Results
AMU postgraduate doctors in training and locally employed doctors rota mapping
Evidence of National Early Warning Score (NEWS) training, attendee list and feedback document
AMU Hillingdon Consultant Cover rota 2022
Intensive Care Unit (ITU) referral audit data analysis and presentation

The review panel also considered information from the GMC National Training Survey 2019 and 2021 and Health Education England's (HEE) National Education and Training Survey (NETS) 2019 to 2021.

This information was used by the review panel to formulate the key lines of enquiry for the review. The content of the review report and its conclusions are based solely on feedback received from review attendees.

Review Panel

Role	Name, Job Title
Quality Review Lead	Dr Bhanu Williams, Deputy Postgraduate Dean, North West London, Health Education England (London)
Specialty Expert	Dr Catherine Bryant, Deputy Head of School of Medicine Health Education England Dr Celia Bielawski, Deputy Director of North Central Thames Foundation School, Health Education England
Lay Representative	Anne Sinclair, Lay Representative, Health Education England
Learner Representative	Dr Rajvi Shah, Acute Internal Medicine Doctor in Postgraduate Training (DPT) Representative
GMC Representative	Lucy Llewellyn, Education QA Programme Manager, General Medical Council
HEE Quality Representative(s)	Paul Smollen, Deputy Head, Quality, Patient Safety & Commissioning, Health Education England, London Rebecca Bennett, Learning Environment Quality Coordinator Health Education England (London)
Supporting roles	Ummama Sheikh, Quality, Patient Safety and Commissioning Officer Health Education England (London) Shabina Mirza, Quality, Patient Safety and Commissioning Officer Health Education England (London) (Observing)

Executive Summary

The review panel thanked the Trust for accommodating the review.

The Trust representatives acknowledged the serious nature of the concerns raised at the last quality review in November 2021 and noted they were aware that these issues had been ongoing for a number of years. However, the Trust representatives informed the review panel that the Acute Medical Unit (AMU) was in a much better position than in previous years and that a number of changes had been made. The review panel noted that the Trust had worked hard on consultant support and recruitment, educating trainers about exception reports and how to offer feedback to Doctors in Postgraduate Training (DPTs). It was noted that this had translated well into a more positive experience for DPTs. DPTs acknowledged that they had noticed improvements recently and as a result the majority of DPTs reported that they would recommend their post to colleagues.

The review panel was informed by the DPTs that the additional consultant input from the West Middlesex University Hospital (WMUH) consultants and the new substantive consultant had been helpful in providing additional clinical supervision and improving the quality of the training environment.

The review panel was pleased to note the work that had been done with some of the consultants about their behaviours and the fact that the current DPTs did not report any bullying or undermining behaviour. The review panel was also pleased to hear strong positive feedback for the nursing team which was consistent with feedback from previous quality reviews.

The review panel acknowledged there had been significant improvement in the culture for exception reporting and DPTs reported they were actively encouraged to exception report. However, it was noted that the learning from exception reports was not being reviewed and implemented.

The review panel was concerned that there were ongoing issues with lack of differentiation in workload for different levels of DPTs. The review panel also noted that there were still considerable improvements needed to develop a clear and robust handover process. The review panel heard that the issues with handover were compounded by the rota, with DPTs starting and finishing their shifts at different times.

This report includes a number of requirements and recommendations for the Trust to take forward, which will be reviewed by HEE as part of the three-monthly action planning timeline. Initial responses to the requirements below will be due on 1 September 2022.

Review Findings

This is the main body of the report and should relate to the quality domains and standards in HEE's Quality Framework, which are set out towards the end of this template. Specifically, mandatory requirements in the sections below should be explicitly linked to the quality standards. It is likely that not all HEE's domains and standards will be relevant to the review findings.

Requirements

Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
M1.5	The review panel felt that there were still considerable improvements needed to develop a clear and robust handover process. It was noted there was a risk that patients could be missed. The review panel also noted that the issues with handover were compounded by the rota, with Doctors in Postgraduate Training (DPTs) starting and finishing their shifts at different times.	The Trust must review the handover process for all handovers in the Acute Medical Unit (AMU) and make changes to the process so that there is a robust system in place to handover patients. The Trust should also address the lack of consistency with the rota to prevent the necessity for multiple handovers. The Trust should consult this work in partnership with the DPTs. Please also provide feedback from DPTs on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
M2.6	The review panel acknowledged there had been significant improvement in the culture for exception reporting and Doctors in Postgraduate Training (DPTs) reported they were actively encouraged to exception report. However, it was noted that the learning from exception reports was not being reviewed and implemented. DPTs also reported that they had not been remunerated for the reports they had submitted, despite approval from their supervisors.	The Trust should ensure that all exception reports are reviewed, and learning is from the reports is actioned. The Trust must also ensure that DPTs are renumerated in a timely manner for reports which have been submitted and approved. Please also provide feedback from DPTs on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
M3.5	The review panel was concerned that there was not consistent and clear consultant	The Trust must conduct an urgent review of the supervision arrangements for DPTs working

	supervision for Doctors in Postgraduate Training (DPTs) in the Ambulatory Emergency Care Unit (AECU). DPTs reported that they were often the most senior doctor in the unit and were not always clear on who they should escalate issues to.	in the AECU ensure that DPTs have access to appropriate levels of clinical supervision and learning opportunities when working in the AECU. Please provide evidence that this has been done and that clinical supervision in the AECU meets DPTs needs. Please also provide feedback from DPTs on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
M5.1a	The review panel was informed that there continued to be issues with lack of differentiation in workload for different levels of Doctors in Postgraduate Training (DPTs). The foundation DPTs reported that the DPTs and Locally Employed Doctors (LEDs) shared patients equally between them. The foundation DPTs advised the review panel that they had found it strange that the specialty DPTs were doing the same work as the foundation DPTs. The specialty DPTs also confirmed that there was no differentiation in the workload. The specialty DPTs reported that the DPTs had attempted to divide the work according to experience level themselves. The consultants informed the review panel that they were reviewing the model of how work was divided and differentiated between the	The Trust must ensure that DPTs have access to opportunities which are relevant to their level of training. Please provide evidence that this issue has been resolved. Please also provide feedback from DPTs on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.

	different level of DPTs and LEDs.	
M5.1b	The review panel noted that, separately, the Doctors in Postgraduate Training (DPTs) and the consultants had good ideas on how to improve the rota, differentiation in workload and team structure. The consultants informed the review panel that there was not much DPT representation at the LFGs and felt that DPT participation in these meetings was low. The Trust representatives acknowledged that DPTs had reported that they had found it difficult to attend the LFGs, teaching and the focus groups. It was noted that DPTs often had to decide whether to attend and finish late or miss the opportunity and finish on-time.	The consultants, DPTs and Locally Employed Doctors (LEDs) should be brought together for focused conversations on making improvements. The Trust must improve DPT engagement with Local Faculty Group meetings (LFGs) and also ensure that workloads enable DPTs to attend various feedback forums. Please also provide feedback from DPTs on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.
M5.6a	Specialty Doctors in Postgraduate Training (DPTs) felt that five doctors on the Acute Medical unit (AMU) as a minimum would be safer and noted that with five DPTs and Locally Employed Doctors (LEDs), they were better able to accommodate teaching, reflection breaks and case discussions with colleagues. The foundation DPTs confirmed that they had found it difficult to attend teaching as they felt they would have to stay late or sacrifice their lunch breaks to offset the time. Some consultants commented that sometimes the DPTs had not been able to attend teaching and noted that it had depended on the number of DPTs and LEDs working on the day.	The Trust should review the workload of DPTs and the staffing levels to ensure that the rotas and workload enable DPTs to attend teaching and education opportunities needed to meet curriculum requirements. The Trust must support trainees to attend programme specific education activities as necessary and this time should be adequately protected. Please also provide feedback from DPTs on this topic, via Local Faculty Group (LFG) meeting minutes or other evidence. Please submit this evidence by 1 September 2022, in line with HEE's action plan timeline.

Immediate Mandatory Requirements

Requirement Reference Number	Review Findings	Required Action, Timeline and Evidence
N/A		
Requirement Reference Number	**Progress on Immediate Actions**	**Required Action, Timeline and Evidence**
N/A		

Recommendations

Recommendations are not mandatory but intended to be helpful, and they would not be expected to be included within any requirements for the placement provider in terms of action plans or timeframe. It may however be useful to raise them at any future reviews or conversations with the placement provider in terms of evaluating whether they have resulted in any beneficial outcome.

Reference Number	Related HEE Quality Framework Domain(s) and Standard(s)	Recommendation
N/A		

Good Practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that, in the view of the Quality Review Team, enable the standards within the Quality Framework to be more effectively delivered or help make a difference or improvement to the learning environment being reviewed. Examples of good practice may be worthy of wider dissemination.

Learning Environment/Professional Group/Department/Team	Good Practice	Related HEE Quality Framework Domain(s) and Standard(s)
N/A		

HEE Quality Domains and Standards for Quality Reviews

HEE Standard	HEE Quality Domain 1 Learning Environment and Culture	Requirement Reference Number
1.1	**The learning environment is one in which education and training is valued and championed.** Foundation Doctors in Postgraduate Training (DPTs) reported that generally their experience had been positive. It was noted that the Acute Medical Unit (AMU) had been fast paced but DPTs noted that this had been the case in other AMUs at different Trusts. DPTs reported a positive working environment on the AMU. Some of the foundation DPTs advised that they would not recommend their post in the AMU as they felt there was an element of training being hindered in order to support the service needs. Several foundation DPTs reported that they often had to stay late and had to catch up on learning at home as there was not enough time to read around cases or for reflection at work. It was noted that some of the foundation DPTs felt the environment in the AMU was not conducive to learning. However, several DPTs informed the review panel that they would recommend their posts as the team had been very supportive and they felt that there had been a lot of improvement since the last Health Education England (HEE) quality review. It was noted that the DPTs had noticed the efforts to make improvements. Several specialty DPTs reported that they had found working on the AMU to be very busy and had found it stressful. The DPTs reported that the workload had been very high and that it had been difficult to access education opportunities and training on the unit. However, specialty DPTs noted that there had been a number of positive improvements recently, including the addition of the West Middlesex University Hospital (WMUH) consultants and the recruitment of a substantive consultant. Specialty DPTs advised the review panel that they felt this was a positive step and was important for a good quality learning environment. DPTs also felt encouraged that issues had been acknowledged and that there had been efforts to make improvements. There was a mixed response from specialty DPTs when asked whether they would recommend their training post to a colleague. The majority of specialty DPTs reported that they would recommend their training post as there was a wide variety of patients and it was a busy unit therefore offered a lot of valuable learning experiences. Some specialty DPTs noted there had been opportunities to manage patients more independently and develop their decision making and time management skills. The DPTs acknowledged that further improvement work was required	

	but noted that they had had an enjoyable experience working in the AMU. However, some specialty DPTs reported that they would not recommend their posts as they felt the balance between service provision and learning was not ideal for a learning environment. All specialty DPTs clarified that they would be more likely to recommend their training post if the workload was more differentiated and specific to the level of training.	
1.3	**The organisational culture is one in which all staff are treated fairly, with equity, consistency, dignity and respect.** The Trust representatives informed the review panel that following the previous quality review they were saddened and disappointed to hear there had been issues with consultant behaviour and noted that a number of measures had been taken to make improvements. The Trust representatives reported that they had worked closely with the DPTs following the previous quality review and had ensured that all DPTs had support from their educational supervisors (ES). It was noted that the Trust had offered the DPTs support if they wanted to raise formal complaints, however it was clarified that no complaints had been made. The Trust representatives informed the review panel that the department had sought support from Human Resources (HR) and that the consultants had also been offered support too. The Trust representatives clarified that they felt that the poor behaviours had been adopted across the group and acknowledged there were fundamental issues and misunderstandings on how to give feedback. The review panel was informed by the Trust representatives that training sessions had been delivered for the AMU consultants to address these issues. It was also noted that some consultants were also receiving coaching sessions to address difficult behaviours. The Trust representatives advised that there had not been any concerns raised by DPTs about this issue following the improvement actions. All DPTs reported that they had not witnessed or experienced any bullying or undermining behaviours. Some DPTs reported that there was a consultant who did not communicate well with the DPTs and Locally Employed Doctors (LEDs) on the post-take ward round, which made DPTs feel uncomfortable. It was noted that this consultant did not work on the AMU frequently.	
1.5	**Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.** Some DPTs informed the review panel that they would be comfortable for their friends and family to receive care in the AMU. DPTs noted that it was dependant on which consultants were working and the staffing levels. However, all DPTs advised	

	the review panel that they would be happy for their friends and family to receive care from the nursing staff on the AMU as they had witnessed excellent patient care from the nursing team. Specialty DPTs advised that they would be apprehensive with their friends and family being treated if they had to be moved between different wards as they had witnessed patients being lost in the system during transfer and they felt the management of medical outliers was not optimal. The majority of foundation DPTs noted that they would not be comfortable for their friends and family to receive care on days that were busy as they had felt rushed and there had been pressure to discharge patients quickly to clear beds. It was noted that there had been some improvement in the staffing levels with the support from the WMUH consultants. The Trust representatives reported that there was a new handover process which was currently being tested. It was noted that the aim was to improve data quality and availability. The consultants advised the review panel that there was work ongoing to improve the handover processes in the unit. It was noted that this work included input from the DPTs, new consultants and the Information Technology department (IT). The Trust representatives also reported that changes had been made to the rota, staring in August 2022, which would allow for a more effective handover at the weekend. Trust representatives informed the review panel that the DPTs working on the weekend would also be working on Fridays to improve continuity of handover across the weekend. It was noted that this change would result in one foundation DPT on the rota requiring an additional zero-day, but the Trust representatives clarified that this would be accommodated. The consultants advised the review panel that these changes had been made recently and that the changes had been made in consultation with the DPTs. The consultants acknowledged that the change would require further development as it had only recently been implemented. The Trust representatives informed the review panel that there was a weekday handover every morning in the education centre. The consultants also informed the review panel that medical outlier patients were documented on a list and the consultants reported that if patients had been moved overnight these patients were not formally handed over but were discussed with the other teams in this meeting. The consultants clarified that the teams handed over between themselves when the patients were moved. It was noted that there was also an evening handover at 21:00, with input from surgery and the Intensive Care Unit (ITU).	

	However, Trust representatives acknowledged that this handover was not fully developed yet. The foundation DPTs reported that there was no formal AMU handover in the morning and noted that only emergent information was handed over by the consultants. The consultants confirmed that there was no formal AMU handover in the morning. The DPTs noted that DPTs usually picked up their patients and prepped them for the ward round. The DPTs reported that the post-take patients were documented on a board and the DPTs reviewed the post take documentation and got started on the job list and preparation work. The DPTs advised that they had not had any issues with this process so far. The consultants informed the review panel that patients who had been referred to AMU overnight were picked up during the ward round and any acutely unwell patients were reviewed first. Specialty DPTs reported that during the day a foundation DPT based in the Emergency Medicine (EM) department cared for post take patients. It was reported that sometimes these patients had been transferred to AMU the foundation DPT was not made aware and the AMU team had also not been made aware. DPTs noted that it was also unclear who was responsible for these patients and reported that there were often several discussions about this. It was noted that DPTs would find it helpful for the team to be ready for the patient before they arrived in the department and for the lines of responsibility to be clearer. The consultants advised the review panel that there had been issues with patients staying longer in the EM department whilst they were allocated to the relevant specialities. The DPTs informed the review panel that they and LEDs had different shift patterns with staggered start and finish times, with DPTs working 07:00-15:00, 08:00-16:00 and 09:00-17:00. Foundation DPTs reported that at the end of the day the foundation DPTs handed over to the doctor working 09:00-17:00 who then handed over to the on-call team who started at 17:00. DPTs reported that there was often not enough time for a detailed handover and DPTs felt that some background information was lost. DPTs clarified that all of the clinical information was documented but felt that the patient story was somewhat lost. DPTs also reported that when they had to handover to the on-call team at 17:00 they often had to stay late as they were only scheduled to work until 17:00 themselves, therefore there was no overlapping time for handover. Specialty DPTs reported that it was sometimes difficult to cover the AMU between 15:00 and 17:00. DPTs reported that it was not always possible for the DPTs	Yes, please see M1.5 Yes, please see M1.5 Yes, please see M1.5

	working 09:00-17:00 to pick up the patients handed over by the DPTs finishing at 15:00. Some specialty DPTs also reported that the post-take EM foundation DPT did not always return to AMU to hand over patients before they left. The foundation DPTs reported that the weekend handover was conducted via a shared computer document. DPTs reported that the Friday handover information was documented in a Microsoft Word document and the DPTs working on Saturday reviewed this document. The DPTs reported that they asked the consultant on Friday for the plan for the weekend and documented this in the handover document for the rest of the weekend team. It was noted that the foundation DPTs and the consultant discussed and decided which patients needed to be reviewed over the weekend. The foundation DPTs advised the review panel that this process worked well providing all of the necessary information had been provided and the reasoning for decisions had been documented. Some foundation DPTs informed the review panel that this process did not work well on bank holiday weekends, particularly when patients move to a different ward. It was noted that if patients arrived after 17:00 on the Friday of a bank holiday weekend there was a risk they could be missed as they were not on the list to be reviewed. DPTs clarified that usually patients like this were picked up at the morning handover, but this had not happened on bank holiday weekends. DPTs also reported that doctors covering other wards did not review the AMU handover document at the weekend therefore AMU based trainees had to handover patients to the specific ward the patients were being transferred to. The specialty DPTs reported that AMU was a large ward with a high turnover of patients and noted that often patients had arrived very unwell. However, if the nurses had not flagged these patients the doctors would not have been aware of them as they were not always handed over. Specialty DPTs informed the review panel that often patients would be transferred to AMU without any formal handover and there had been occasions where urgent tests had been delayed due to this. Specialty DPTs advised the review panel that they felt this was unsafe. It was also noted that when patients had moved between zones it had been challenging to access important scans and referrals in a timely manner at the weekend. DPTs noted that they had spent a lot of time chasing this. The specialty DPTs reported that they felt the weekend ward cover arrangements across the hospital seemed stretched and found it challenging to cover the workload with the number of staff	Yes, please see M1.5 Yes, please see M1.5

	available. The specialty DPTs commented that they believed there was some work ongoing to resolve these issues and explore how the weekend cover could be improved, however the DPTs were not aware of the progress of this work. Specialty DPTs reported that they had been informed that the Enhanced Medical Care Unit would be moved to the Respiratory Team and the responsibilities would be redistributed. It was noted that this would help reduce the workload for DPTs at the weekend. Some DPTs reported that as part of the medicine on-call, DPTs were called to review patients in AMU. It was noted that the on-call was quite busy. Some DPTs reported that when working on post-take and discharge there was a lot of pressure to send patients home quickly. As a result, DPTs noted that they sometimes felt rushed in AMU which they found stressful. The specialty DPTs reported that there were two speciality DPTs on call for medicine. It was noted that one DPT covered the admissions, and the other DPT covered the wards. Specialty DPTs reported that there was a post-take consultant who reviewed patients who had been admitted overnight. The Trust representatives reported that there had been an audit of referrals from AMU to the ITU. Trust representatives reported that the Covid-19 pandemic had impacted on the referrals process and less experienced DPTs had been doing some of the referrals. However, it was noted that the new ITU referral process was in place and the feedback from DPTs had been positive.	
1.12	**The learning environment promotes multi-professional learning opportunities.** The DPTs spoke very highly of their nursing colleagues on the AMU, noting the teamwork, practice, culture and experience they give DPTs. The review panel was pleased to hear strong positive feedback for the nursing team which was consistent with feedback from previous quality reviews. The Trust representatives reported that there was good input from the pharmacy team on the AMU. However, the Trust representatives acknowledged that there were gaps across the Trust. It was noted that there were plans to recruit more prescribing pharmacists. It was also reported that the medicine department had produced a business case to recruit Physician Associates (PA) which had been submitted to the senior management team and the department were waiting for the outcome. It was noted that at least one of these PAs was planned to support AMU.	

HEE Standard	HEE Quality Domain 2 Educational Governance and Commitment to Quality	Requirement Reference Number
2.4	**Education and training issues are fed into, considered and represented at the most senior level of decision making.** The Director of Medical Education (DME) informed the review panel that they met with the Medical Director (MD) monthly and felt supported to raise issues.	
2.6	**Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.** The Trust representatives advised that DPTs felt more able to exception report and as a result the number of exception reports had increased. The Trust representatives reported that the culture of exception reported was more embedded and DPTs were encouraged to exception report when necessary. The Guardian of Safe Working Hours (GoSWH) commended the work done by the Postgraduate Medical Education Team (PGME) to improve the culture of exception reporting and confirmed that the DPTs had been more comfortable to report. The GoSWH informed the review panel that the Trust had been working on a mandatory training for supervisors which was due to be implemented in the next six months. Some DPTs confirmed they had received training on how to exception reporting. However, some DPTs reported that they had not received formal training but had been guided through the process by their supervisors whilst submitting the reports. All foundation DPTs reported that they had been well supported by consultants to exception report. Specialty DPTs reported that often their exception reports were not discussed with supervisors and DPTs also reported that they had not been remunerated for the reports they had submitted, despite approval from their supervisors. The Trust representatives reported that the education and leadership teams had worked to implement actions to drive improvement and noted that issues with lack of substantive consultant cover had been difficult to resolve due to a number of unsuccessful appointments. However, the Trust representatives informed the review panel that a new substantiative consultant had been recruited and had started in the department. It was also noted that consultants from WMUH had started to provide support to AMU. It was noted that there were four consultants who shared the rota to work at Hillingdon Hospital on Monday,	Yes, please see M2.6

	Tuesday, Thursday, and Friday. The Trust representatives clarified that this support arrangement had been agreed for one year and that the objective of the WMUH consultants was to ensure that DPTs were supported, were attending teaching and that concerns from DPTs were resolved. It was also noted that the WMUH consultants had also provided support for the induction of the new substantiative consultant and help to develop the clinical pathways in the department. The Trust representatives reported that the WMUH consultants were providing weekly feedback to help inform improvements. The WMUH consultants suggested that the Thursday feedback session could be adapted to support a Local Faculty Group meeting (LFG) structure and the DPTs could be included to enable them to provide feedback on improvements. The Trust representatives reported that the Trust had been running training session for nursing staff on National Early Warning Score (NEWS). It was reported that 21 nurses had attended so far, and the feedback had been positive. The Trust representatives noted that they planned to build on this success. The Trust representatives informed the review panel that following the previous quality review there had been a lot of work on DPT engagement as it was acknowledged there was a disconnect between the management and trainee perspective. The Trust representatives reported that the PGME were collecting fortnightly feedback from DPTs in the department to track the progress of the improvements. It was noted that the PGME had also had confidential focus group meetings with the DPTs and the Medical Education Manager (MEM). The Trust representatives also reported that medicine LFG had been more frequent following the HEE quality review in November 2021. The consultants informed the review panel that there was not much DPT representation at the LFGs and felt that DPT participation in these meetings was low. It was noted that they felt this was across all of the LFGs, not just the medicine one. The consultants informed the review panel that they had encouraged the DPTs and LEDs to attend to share their feedback and ideas for improvements. The consultants acknowledged that they may need to ensure DPTs understand the importance of these meetings and make them a priority. It was noted that the consultants planned to add this to the induction. The consultants also reported that it might be helpful for the AMU to have their own LFG in which DPTs could give specific feedback.	
2.7	**There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.**	

	The WMUH consultants reported that the Hillingdon AMU had good patient flow and clinical decision making. It was noted that the AMU had potential and structurally the unit had a lot of clinical space which could be optimised. The WMUH consultants also reported that they were supporting the department to develop pathways. The WMUH acknowledged there was scope for improvement in the unit but noted that there had been improvements. The WMUH consultants informed the review panel that they believed the improvements had already positively impacted the DPT experience, noting DPTs seemed happier and more comfortable.	

HEE Standard	HEE Quality Domain 3 Developing and Supporting Learners	Requirement Reference Number
3.5	**Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.** The consultants reported that the consultant office was adjacent to the AMU and that there was an open-door policy. It was also noted that the consultants were available via a WhatsApp group. The review panel discussed clinical supervision and the DPTs advised that they were aware of who to contact for support. Specialty DPTs reported that when working on the medicine on-call they felt able to contact a consultant if they needed to. It was noted that foundation DPTs usually contacted the specialty level DPTs who were responsible for ward cover to escalate concerns initially. The DPTs reported that there was a consultant-led ward round and two board rounds per day. The DPTs reported that they had found this very helpful, although the DPTs noted that the ward round was quite fast paced. Specialty DPTs noted that at weekends there were consultants onsite to escalate to until 19:00, after which DPTs were able to call the off-site on-call consultants. DPTs also reported that they had felt well supported and that there was always a consultant available on the unit. The foundation DPTs reposted that they were happy with the support from their named clinical supervisors, however some noted that they had not had an initial clinical supervision meeting yet. DPTs informed the review panel that there was no routine consultant-led ward round of patients on AMU at the weekend. DPTs reported that on weekends they were able to call consultants to get advice if necessary. DPTs informed the review panel that they usually received an email when working at the weekend which detailed the team working at the weekend. The review panel was also informed by DPTs that there was a discharge and post-take consultant scheduled for the weekend. The DPTs reported that there was a discharge ward round led by	

	the discharge consultant who covered the whole hospital. It was noted that there was a word document on the Trust intranet which was used to document potential discharges to be reviewed. The consultants confirmed that there was no specific AMU consultant cover for the weekend but advised there was a consultant on-call for outlier patients and discharges. The review team was informed by the consultants that on Fridays all teams prepared a list of potential discharges for the weekend. The Trust representatives reported that there was funding and plans to recruit more consultants for AMU, but that the department was hoping to implement the changes suggested by the WMUH consultants first. The DPTs reported that they were often the most senior doctor in the Ambulatory Emergency Care Unit (AECU) and were not always clear on who they should escalate issues to. DPTs noted that their experience in ACEU had been variable and reported that there was often nobody to answer their questions which they found challenging. It was reported that whilst the understanding was that this unit was not part of the AMU, it was sometimes unclear which department was responsible for the patients in AECU. DPTs noted the management of the patients was different between the Emergency Medicine (EM) consultants and the AMU consultants. The DPTs informed the review panel that there was an EM consultant who ran the AECU for three days during the week, but typically was not available out of hours. It was noted that on the days that this consultant was not working DPTs had found it difficult to access senior advice. The DPTs advised the review panel that they had found this particularly challenging with more complex patients. The consultants advised the review panel that the AMU team were not responsible for the AECU, and that the leadership of this unit had been taken over by the EM department. The consultants informed the review panel that there were AMU senior clinical fellows supporting the AECU and that DPTs were still rotating through the AECU. It was noted that AMU DPTs contacted the AMU consultants for support when they were not able to contact the EM consultants. The WMUH consultants reported that this was an area they might be able to help with as well as they had recently been through this transition at WMUH and therefore could offer some guidance.	Yes, please see 3.5
3.8	**Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.** The Trust representatives were very complimentary of the Internal Medicine Training (IMT) DPTs and commented that they had been working together well as a team.	

3.9	**Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.** The Trust representatives reported that AMU inductions were happening more frequently and were hopefully that the new substantiative consultant would help make this a sustainable change. The Trust representatives also informed the review panel that exception reporting was part of the local and Trust induction.	
3.11	**Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.** The specialty DPTs informed the review panel that the LEDs had been very supportive. It was also noted that the specialty DPTs would have found it helpful for specialty- higher DPTs to be based in the AMU as they would be able to support with training of the foundation and core DPTs. The consultants informed the review panel that they were keen to host acute medical specialty DPTs in the department and reported that they were exploring options to host doctors working towards a Certificate of Eligibility for Specialist Registration (CESR).	

HEE Standard	HEE Quality Domain 4 Developing and Supporting Supervisors	Requirement Reference Number
4.7	**Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.** The review panel inquired about the support systems the Trust had put in place for the new substantive consultant. Trust representatives reported that the new substantive consultant had a mentor and was in close contact with the Clinical Director (CD) to provide support. It was also noted that the medicine department had recruited several new consultants and the new substantive consultant had been encouraged to engage with those consultants for peer support. It was also reported there was a monthly half-day training session for educational supervision and resilience management and the new substantive consultant had been released from clinical duties to attend. The Trust representatives informed the review panel that the new substantive consultant had been introduced to key specialty consultant leads and had been invited to meetings with the ITU consultants.	

	The Trust representatives also informed the review panel that they had organised external educational and clinical supervisor accreditation via Miad Healthcare. It was also reported that exception reporting training had been added to the statutory and mandatory training requirement for consultants and had been added as a specific module as part of the Miad Healthcare training programme. The consultants reported that the Trust had been supportive and there had been a lot of encouragement for training. It was noted that there had been comprehensive support for education and development. Consultants advised the review panel that they had felt more supported following the previous HEE quality review and felt able to access help and support if they needed to.	

HEE Standard	HEE Quality Domain 5 Delivering Programmes and Curricula	Requirement Reference Number
5.1	**Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.** The foundation DPTs reported that the DPTs and LEDs shared patients equally between them. The foundation DPTs advised the review panel that they had found it strange that the specialty DPTs were doing the same work as the foundation DPTs. However, the foundation DPTs clarified that they were completing work that was appropriate for their training level. Specialty DPTs advised the review panel that they usually cared for 8-10 patients each and were frequently expected to do a large number of discharge summaries and have difficult conversations with families without direct support. The specialty DPTs also confirmed that there was no differentiation in the workload. The specialty DPTs reported that the DPTs had attempted to divide the work according to experience level themselves. The DPTs noted that they had also attempted to pair up specialty DPTs with the foundation DPTs, so the specialty DPTs were able to focus on patients who were more acutely unwell. However, the specialty DPTs noted that there had been some resistance from the consultants in the unit who were used to the previous system. It was also noted that the DPTs had struggled to implement this as the variable shift patterns of the DPTs made it difficult to distribute the workload. The specialty DPTs also reported that the on-call rota also made it challenging to pair up DPTs as the rota was variable and there was a different team every day. The specialty DPTs advised the review panel that they had attempted to make changes to differentiate the workload but felt that they needed more support from the department and	Yes, please see M5.1a Yes, please see M5.1a Yes, please see M5.1b

	an appropriate forum to suggest changes and have an input into improvements. The consultants informed the review panel that they were reviewing the model of how work was divided and differentiated between the different level of DPTs and LEDs. It was noted that the current model involved one doctor looking after one bay. The consultant reported that one of the options was to have teams with one consultant and two DPTs /LEDs, one of which would be a specialty DPT. The review panel enquired whether the DPTs had been consulted about these plans and the consultants reported that this had not happened yet but that there were plans to do this in the upcoming weeks. The consultants informed the review panel that they had been doing more bedside teaching. DPTs informed the review panel that previously there had been few opportunities for bedside teaching but noted that with the additional consultants there had been more capacity for this. DPTs reported that the recently implemented 10-minute case-based discussions with consultants had been helpful, although some DPTs noted they had not experienced these discussions yet.	Yes, please see M5.1b
5.6	**Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.** The consultants advised the review panel that they had encouraged DPTs to attend teaching and had requested that DPTs handed over work to the consultants so they could attend. The consultants noted that they hoped this would continue to improve. The WMUH consultants informed the review panel that they felt the additional consultant support had alleviated pressure on the Hillingdon consultants and this had allowed a more relaxed teaching approach and ward round. It was noted by the DPTs, WMUH consultants and Hillingdon consultants that more staff had enabled the supervisors to conduct bedside teaching and arrange a teaching rota which had been mapped to the curriculum. The review panel was informed by the consultants that there was AMU specific teaching every Thursday and case-based teaching on Tuesday. It was noted that feedback from the trainees had been positive. The consultants also reported that they offered Practical Assessment of Clinical Examination Skills (PACES) teaching for those who were undertaking that exam. The Trust representatives reported that DPTs had reported that consultant cover had improved but that there was an issue with staffing more generally and DPTs felt that more DPTs or LEDs were needed to help with the workload. The foundation DPTs advised the review panel that they felt the minimum staffing levels	

	set by the department were too low. It was noted that DPTs had stayed late most days. The DPTs informed the review panel that there had been days where some of the consultants had commented that they were overstaffed, however the DPTs believed that this level was actually only a minimum staffing level. The DPTs believed this had impacted their training as they had not been able to attend teaching or have sufficient time to do assessments. Some specialty DPTs reported that they often did not have time for a lunch break when working in the AMU and that they frequently left work late. The specialty DPTs reported that a specialty DPT was named as the AMU lead and therefore other DPTs would escalate issues to them in the first instance. It was noted that it was challenging to do this and manage their own patients. The foundation DPTs informed the review panel that there was usually a minimum of four postgraduate doctors in training and LEDs working in the AMU. DPTs noted that this was fine providing there were no acutely unwell patients. Specialty DPTs felt that five doctors on the Acute Medical unit (AMU) as a minimum DPTs be safer and noted that with five postgraduate doctors in training and LEDs, they were better able to accommodate teaching, reflection breaks and case discussions with colleagues. The specialty DPTs also reported that more consistent consultant availability would also be helpful to aide in balancing service provision and educational responsibilities. The Trust representatives acknowledged that DPTs had reported that they had found it difficult to attend the LFGs, teaching and the focus groups. It was noted that DPTs often had to decide whether to attend and finish late or miss the opportunity and finish on-time. The foundation DPTs confirmed that they had found it difficult to attend teaching as they felt they would have to stay late or sacrifice their lunch breaks to offset the time. Foundation DPTs informed the review panel that some DPTs attempted to do teaching and cover their work at the same time, but it was noted that this had not been very effective. Some foundation DPTs acknowledged that there seemed to have been improvements from previous rotations in being able to attend teaching and self-development days but commented that they often had to work through their lunch break to avoid leaving late. Specialty DPTs reported that they had been able to attend teaching and the consultants had encouraged the DPTs to attend. The specialty DPTs informed the review panel that the time for teaching was somewhat protected unless there was a particularly emergent case. The consultants informed the review panel that all DPTs were able to attend teaching and that they actively encouraged them to attend. However, some consultants commented that sometimes the DPTs had not been able to attend teaching and noted that it had depended on the number of DPTs and LEDs	Yes, please see 5.6a Yes, please see M5.6 Yes, please see 5.1b Yes, please see 5.6a

	working on the day. It was noted that it had been easier to access protected teaching time with the return of face-to-face teaching as DPTs could leave the unit to attend.	

HEE Standard	HEE Quality Domain 6 Developing a sustainable workforce	Requirement Reference Number
	Domain not discussed at this review	

Report Approval

Quality Review Report completed by	
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Final Report submitted to organisation	8 July 2022