Health Education North Central and East London
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Developing people for health and healthcare

Pan-London Quality and Regulation Unit

North Middlesex Hospital NHS Trust

Emergency Medicine (EM)

Quality Visit Report

Date of visit: 1 July 2015

Version Final Report

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Health Education
North Central and East London

CONVERSATION OF CONCERN REPORT

Visit Details	
LEP	North Middlesex University Hospital NHS Trust
Specialty	Emergency Medicine (EM)
Date of visit	1 July 2015
Background to visit	It was bought to the attention of Health Education North Central and East London (HE NCEL), that concerns previously shared with the Trust in regards to the quality of education and training in the Emergency Department at North Middlesex University Hospital remain on going. HE NCEL as the responsible commissioner for the Trust and as the accountable body to the General Medical Council, were obliged to investigate these concerns further. The concerns raised to HE NCEL, regarded the following: • Bullying and undermining behaviour following concerns being raised with HE NCEL by trainees earlier in the year. • Excessive and unmanageable workload in the emergency department at North Middlesex University Hospital. • Poor educational focus within the department where it is alleged that the primary focus is on the provision of service, with little education and training. Subsequent to the conversation of concern being organised the GMC National Trainee Survey results for 2015 were released. Disappointingly, the Trust and in particularly the department generated a high proportion of negative outliers. In particular, emergency medicine foundation year 2, received 11 red outliers out of the 12 available indicators in foundation, with three of these being recurring reds (clinical supervision, handover and study leave). Emergency Medicine generated red outliers in clinical supervision out of hours, handover and study leave, with pink outliers in overall satisfaction.
Visit summary and outcomes	The visit team met with the chief executive, medical director, director of operations, assistant director of medical education and development, emergency department clinical director and urgent care centre service manager. The visit team met with 18 trainees across general practice (GP), foundation, acute care common stem (ACCS), defined route of entry into emergency medicine (DRE-EM) trainees and higher emergency medicine trainees. The visit team also met with a paediatrics specialty trainee who regularly worked in the paediatric emergency department (ED). The visit team met with seven consultants and the college tutor whom was also the patient safety lead for the emergency department.

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	The visit team did not provide feedback on the day of the visit. The chief executive was informed of the visit outcome on 2 July 2015. The visit team would like to commend the trainees of all grades for the feedback they provided to the visit team despite their apprehension in doing so. The visit team heard reports of variability in support provided by clinical supervisors to trainees, undermining and bullying attitudes, and concerns with regards to patient safety care. Concerns raised during the visit about the clinical decisions and management of a number of non-training middle grade doctors and consultant staff have been passed directly to the Trust chief executive for investigation.

Visit team

Lead Visitor	Mr Geoff Hinchley, Head of the London Specialty School of Emergency Medicine	**Trust Liaison Dean**	Dr Andrew Deaner, Trust-Liaison Dean for North Central and East London
General Medical Council Representative	Ms Jennifer Barron, Quality Assurance Programme Manager	**General Medical Council Representative**	Dr Craig Steele, GMC Enhanced Monitoring Associate
Lead Provider	Dr Helen Cugnoni, Training Programme Director for University College London Partners	**Foundation School Representative**	Dr James Dooley, North Central Thames Foundation School Director
Lay Member	Ms Jayam Dalal, Lay Representative	**Scribe**	Miss Michelle Turner, Quality and Visits Officer

Findings

GMC Domain	Ref	Findings	Action and Evidence Required. Full details on Action Plan	RAG rating of action
1	1.1	**Clinical Supervision** The clinical director reported that there was 16 hours of consultant cover in the department each weekday, with consultants available from 8am – midnight. Trainees were told at the	A review of and improvements to the clinical support given to trainees is required. A pro-active approach to supporting the clinical work of trainees is needed. Thresholds for providing additional	**Amber** Mandatory Requirement

		induction, that they had to discuss every case with a senior colleague. The trainees reported that although consultants were available the quality of advice given by consultants was variable. It was reported to the visit team that some consultants, when asked for advice about patients, would frequently advise that the patient be discharged without having heard the full history. The trainees stated that in such situations a consultant would rarely review a patient directly unless they specifically said 'I need you to come to look at this patient'. The core trainees stated that when uncertain about the standard of clinical advice given by a consultant they would speak to the on call medical higher trainee or the emergency medicine (EM) specialty trainee. The visit team found that 15 out of the 18 trainees met by the visit team reported having to deal with situations beyond their competence without appropriate supervision on a regular basis. This was not specific to normal hours or out of hours. The foundation year two (FY2) trainees advised the visit team that they would neither recommend the emergency department (ED) for treatment to their family and friends, nor for training to a colleague. The educational supervisors confirmed that they were also clinical supervisors, and were responsible for both training and non-training grade doctors. Considering the number of junior and middle grade doctors in the department this meant that many consultants were supervising five or more doctors.	support at times of heavy workload or when complex patients are admitted should be agreed so that trainees do not feel they are working beyond their capacity or capabilities, particularly in the resuscitation room.	
1	1.2	**Clinical Supervision at Night/ Out of Hours** The trainees stated that there were two non-training middle grade doctors out of hours, and there would be a third if one of the EM trainees were on call. There would be four or five foundation or general practice doctors working in the ED overnight. The trainees had recently been encouraged by the clinical supervisors to call consultants out of hours. They were informed that this had been stated at the department induction but none of the trainees	An urgent review of out of hours cover is required. Improvements must be made so junior trainees feel well supported at all times.	**Amber** Mandatory Requirement

		were aware of this. The trainees reported that generally the amount of clinical supervision out of hours was acceptable. However, the quality of supervision was variable; this heavily depended on who was on the shift and how busy the department was. Trainees reported that often they felt unsupported. The foundation trainees reported that there had been numerous incidents when they had been the only doctor in the resuscitation area of the ED, often for long periods. The trainees reported feeling alone, uncomfortable and unsupported. The visit team heard of one incident when a trainee called a colleague for help and was told to 'hurry up' with managing patients in the resuscitation area as there were patients in the minors area who were close to or had already breached the four hour waiting time target. The trainees stated that they were aware of at least two clinical incidents which occurred in the resuscitation area that may have been prevented if staffing levels were increased. The trainees commented that since the training in anaesthetics had been suspended, there was minimal critical care support in the department, with variable levels of intensivist support. The trainees reported that some of the anaesthetic non-training grades were helpful and would assist but others were not.	Rotas should be organised to enable all patients in the resuscitation room to be reviewed by a middle grade or senior doctor. The department should introduce and enforce the use of clinical risk scoring strategies to ensure that the sickest patients are dealt with as a priority and are reviewed by more senior clinicians. The Trust should review the anaesthetics and ICM support available to patients in the ED and ensure that this is provided in a timely manner.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement **Amber** Mandatory Requirement
1	1.3	**Handover** There was a disconnect between the clinical director and trainees' views on what the handover process should be in the ED. The trainees were of the opinion that the handover process should be clinically focussed on a patient by patient basis with the outgoing staff handing over to the incoming staff for the next shift. The clinical director disagreed with this opinion, and believed EM was different to that of other specialties and did not require a formal handover. The trainees reported that the current handover process in place in the ED was ineffective. The department had scheduled daily board rounds. However, the board rounds did not take place consistently and when they did, the meetings were unconstructive. Consultants often	An urgent review of the clinical handover process within the ED is required. With the expectation that a formal, reliable, safe and effective patient focussed handover process is put in place. The Trust must ensure that this new handover process operates both before and after night shifts. The Trust is to provide evidence that this has been implemented, including an audit trail of the handovers during a patient journey.	**Amber** Mandatory Requirement

		shouted at their consultant colleagues, nursing colleagues or the trainees. The trainees often felt bullied or undermined during the meeting. The board round did not go into clinical detail about patients, and patient care but instead, there was a focus on ED waiting times and the number of patients seen by each doctor. Following the board round, the trainees would still have to find their incoming colleague for the next shift to hand over patient care without any supervision or senior input. The educational supervisors commented that there were up to five consultants on the shop floor. There was regular board round to handover patients between teams.		
1	1.4	**Patient Pathways** The senior management team reported that clinical pathways had been put in to place in order to increase the efficiency of the department, such as ambulatory care, observation unit, early-pregnancy unit, self-assessment unit etc. The higher trainees reported that the department had a similar workload to other EDs, but there was a lack of formal process which resulted in the workload and patient flows not being managed effectively. The Trust had developed ambulatory care pathways, but in the trainees opinion these were haphazard, were not being utilised correctly and as a result the trainees described a department lacking in effective processes and pathways and unable to cope with surges in demand. The educational supervisors commented that the main concern of the department was the heavy workload. There were a significant number of patients being admitted into the ED who could be managed via primary care pathways, placing additional pressures on the ED and the wider Trust. The visit team were not convinced that some of the educational supervisors understood the importance of care pathways.	A full review of patient pathways (including paediatrics) within the emergency department is required. Trainees need to be clear regarding alternative pathways for patients who may otherwise need acute admission. The visit team requires that the Trust instigates an external review on patient flows and pathways. This review should also focus on how other departments could support the ED by redirecting patients to other areas of the Trust to be assessed e.g. in early pregnancy units, and accepting appropriate patients referred directly by senior ED nurses.	**Amber** Mandatory Requirement
1	1.5	**Paediatric emergency department** The clinical director stated that he had instigated a survey for trainees to complete regarding	A root and branch review of the management of the paediatric emergency department is required. Trainee doctors need to be clear as to their role in the	**Amber** Mandatory Requirement

		the clinical supervision in the paediatric emergency department. However, it was reported by the trainees that the survey was instigated and carried out by a paediatric higher trainee as a result of concerns regarding the clinical supervision of EM trainees looking after paediatric patients. The visit team were told that the full results and trainee comments had been shared with all trainees, but a redacted version had been sent to the clinical director, and trainees had not received feedback. The clinical director commented that there was sufficient cover in the paediatric ED. There were EM consultants in the morning and middle grade cover in the afternoon. There was cover provided until 10pm by staff in the ED, and out of hours, the whole of the ED i.e. the paediatric and adult teams worked together. The trainees commented that the daytime workload and cover in the paediatric ED was manageable, there was a GP available throughout the day for support. The out of hours cover arrangements and support after 10pm were not adequate. There was rarely EM consultant input. When consultants had come in to help with the workload, they had been known to pick cases with minor injuries which could easily be seen by a foundation trainee year 2 (FY2) trainee so did not necessarily help with the backlog of patients to be seen. The trainees expressed their concerns with consultants appearing unconfident or clinically competent to treat paediatric cases. The trainees stated that they generally received good experience in paediatrics, as the paediatric specialty trainees on call for the department were accessible, supportive and helpful. The trainees confirmed that if they were concerned about a paediatric patient and did not have access to the EM consultants or middle grade doctors they would call the paediatrician on call. Overall the trainees were unclear about who was expected to manage children and young people in the ED. There appeared to be a tendency to avoid involvement with paediatric patients by some non-training middle grade doctors.	management of paediatric patients. Lines of clinical responsibility require clarification, particularly in relation to the assessment and care of very young children.	

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1	1.6	**Emergency Department – Emergency Care Standard** The clinical director commented that the department strongly aimed for the four hour waiting time target in the ED. The clinical director stated that keeping patients waiting longer was not good patient care, and that meeting the target did not create extra pressure on trainees. The trainees stated that in their opinion meeting the four hour waiting time target had taken precedence over patient safety within the department. The trainees felt that there had been occasions, when patients had been hurriedly diagnosed or discharged in order to meet the emergency care standard. The educational supervisors reported that although the department was encouraged to meet the emergency care standards this had not, in their opinion, adversely affected patient safety.	The Trust must implement guidelines and/or escalation plans to ensure that patient care and safety are not compromised to achieve the four hour waiting time target.	**Amber** Mandatory Requirement
1	1.7	**Observation Ward** The trainees felt that the quality of management of patients on the observation ward was highly variable. They felt that this had been a site of frequent clinical incidents due to a lack of clear protocols for the area. On occasion patients were placed on the observation ward rather than definitive management decisions being made. The trainees provided details of specific clinical incidents - these had been passed to the Trust chief executive for investigation.	The Trust is required to provide the current operational policy for the observation unit including details of escalation procedures, lines of clinical responsibility and the frequency of senior clinical review of patients within the department.	**Amber** Mandatory Requirement
1	1.8	**Clinical Incident Reporting** The medical director reported that the department had concerns regarding an increase in mortality rates over the winter period of 2014-15, which was being investigated. The Trust received a recent alert from Dr Foster intelligence service, with regards to an increase in mortalities for urinary tract infections, sepsis and cerebrovascular disease. The Trust patient safety team was currently investigating these concerns. The medical director confirmed that all clinical incidents were reviewed by the patient safety	We would like clarification of the current process for investigating and learning from serious incidents. We would like to know how such learning is shared with trainee doctors. Please confirm if any incidents have involved trainees and whether these have been passed on to HENCEL according to the current protocol. Please also provide the details of the Trust and departmental policies that exist with	**Amber** Mandatory Requirement

		team. The Trust was keen to find patterns in incidents, and kept records of departments and staff involvement. The trainees advised the visit team that they regularly reported clinical incidents but felt that some incidents had been 'swept under the carpet'. The trainees commented that they had reported incidents which had occurred at night, as a result of the level of staffing and paediatrics cover. Some trainees had received informal but satisfactory feedback, but nothing had been shared between departments or formal feedback received. The trainees commented that the patient safety lead for the department was supportive and trainees felt comfortable to raise concerns directly in person. The patient safety lead reported that the feedback from the governance lead had been variable and updates were not always provided in a timely manner. Some incidents thought to be serious had been graded as lower, and vice versa. She could recall incidents that she considered to be serious that had been reported but had subsequently heard nothing further about them.	regards to clinical governance and/ or risk management. Does the Trust have a risk register to include this. The Trust should employ an external independent expert to review the specific cases raised by trainees and also to review the way that clinical incidents and serious untoward incidents have been managed internally, what action plans have been put into place to reduce further clinical risk, what feedback has been provided to individuals involved and whether there is evidence of incidents not being graded or dealt with as seriously as they should be.	**Amber** Mandatory Requirement
1	1.9	**Whistleblowing** The senior management team reported that the whistleblowing policy was discussed at all inductions, and trainees were encouraged to give feedback. The Trust advised that their whistleblowing, and associated, policies were undergoing amendment with regards to the Sir Robert Francis report on the 'Freedom to Speak Up' review. The Trust-liaison Dean attended the Trust on 12 and 19 February 2015 for confidential surgeries, which all trainees were invited to attend. A summary provided to the Trust regarding concerns from trainees had been shared with the EM consultant body, which resulted in alleged undermining behaviours and bullying incidents. The trainees commented that due to the ramifications from the dissemination of the trainee feedback, they had reservations about raising training concerns. However, they would still report incidents when they felt a significant clinical incident had occurred, and would	*Please see the recommendation related to point 6.1*	

		continue to raise concerns whilst they felt that patients were at risk.		
5	5.1	**Curriculum** The clinical director stated that the ED was the second largest single site ED in London, with up to 120 ambulances daily. The clinical director stated that the department workload was challenging, but for trainees it was a positive experience with many opportunities to learn. The clinical director reported that despite the efforts in re–routing patients to reduce workload, there was still limited 'on the job' teaching being delivered to junior doctors. The trainees recognised the huge potential of the department for excellent training based on the volume and variety of pathology. However, they reported that the department did not have a training culture. There were few consultants who were able, capable and willing to provide formal teaching. Trainees received minimal shop floor teaching and this was thought to be as a result of the push to see as many patients as possible and as quickly as possible. The trainees noted that they had received high quality ultrasound training, this particular experience had been excellent, and in addition, the college tutor provided good teaching. The trainees commented that exposure to cases as a higher trainee was generally good. The trainees, however, reported that they do not attend cardiac arrest calls, unless they happened to be in the resuscitation area of the ED at the time a patient was admitted. The trainees commented that they would inevitably deskill, after completion of Advanced Life Support (ALS) training due to the lack of opportunities to lead the cardiac arrest team. The educational supervisors commented that there was a good clinical mix of patients within the department. There was excellent exposure in managing difficult situations and trainees were supported well. Trainees were encouraged to discuss patients with senior colleagues. The educational supervisors reported that the majority of the non-training grade doctors were registered with the e-portfolio. The visit team were unsure if all educational supervisors were up to date with the e-portfolio/curriculum changes taking place from August 2015, as	It is essential that trainees at all grades must have opportunities to be exposed to a large variety of patients ranging from those with minor injuries to the sickest patients in the resuscitation room. Rotas must be constructed to facilitate this and trainers must support the trainees in making the most of the opportunities offered. The department must review the daily distribution of trainees within the department and where appropriate map the available training opportunities against the various curricula to ensure that all trainees are exposed to the full range of clinical cases and training opportunities.	**Amber** Mandatory Requirement **Amber** Mandatory Requirement

		some seemed unsure of the new requirements when questioned by the visit team.		
6	6.1	**Induction** The Trust induction for some trainees clashed with the departmental induction. This caused issues with receiving computer log ins, passwords, completion of administrative work, and learning the ED layout. The trainees found it a stressful and challenging day. The e-learning sessions were only accessible from Trust computers, so there had been delays for all trainees in completing this. Most trainees regarded the departmental induction as inadequate. Most trainees knew who their educational supervisor was. Trainees described difficulties and delays with the allocation of clinical supervisors when starting in EM. Some foundation trainees did not have an allocated clinical supervisor until three months in post. Although trainees were able to complete the required numbers of supervised learning events (SLEs) they often found it difficult to organise regular meetings with the clinical supervisor.	Please ensure that all future Trust and departmental inductions are optimally coordinated. Please review and improve the departmental induction based on evaluation by current trainees ensuring that the Trust induction programme facilitates early allocation of necessary passwords etc Please confirm that future allocation of educational and clinical supervisors will be confirmed prior to the trainees starting in post. Furthermore, the North Central Thames Foundation School requires that all foundation trainees have their educational supervisors allocated for the full year and the clinical supervisor allocated before starting the attachment. A review of the number of trainees supervised by a single consultant is required and confirmation provided that adequate time is allocated within consultant job plans for supervision to be effective	**Amber** Mandatory Requirement **Amber** Mandatory Requirement
6	6.2	**Bullying and Undermining** The chief executive reported the challenges that the department had faced since the confidential surgeries held by HE NCEL in February 2015. The chief executive stated that she was not told the information provided could not be shared. In order to gain the in-depth responses as requested by HE NCEL, she felt they needed to share the full report with the consultants in the department. The clinical director stated that he was concerned about the trainee feedback from the confidential surgeries, as he felt the relationships within the department were 'brilliant'.	A full investigation of the alleged culture of bullying and undermining within the department is required by a person external to the department. This investigation should include recommendations to ensure that the department fosters a positive proactive learning environment of future trainees.	**Amber** Mandatory Requirement

		The clinical director reported that work had been completed to review the department in terms of the environment and how staff worked together. Team building exercises had been completed, and funding was available for coaching of senior clinicians. A multidisciplinary team workshop was to be held in September 2015. The medical director commented that the Trust had commissioned an external review focusing on culture and team dynamics across the multi-disciplinary team. The review covered a three week period, completing diagnostics and every staff member was interviewed independently. The visit team were advised that the outcome of the review was being put together, with feedback for the ED to be made available. The medical director stated that the Trust had a zero tolerance stance in regards to the alleged behaviours following the confidential surgeries. The medical director advised that Trust management actively spoke to trainees, and if trainees raised concerns about being victimised, the Trust would take these seriously. The trainees reported that there was a bullying culture within the department. Trainees had been shouted at in front of patients, medical and nursing colleagues, and feedback from consultants was rarely constructive. Consultants had often shouted at trainees, nurses and other consultants. Trainees confirmed the names of three consultants who were the alleged main culprits of the bullying behaviour. A trainee reported an incident when they had been shouted at by a consultant for being too slow when minors were particularly busy. The visit team heard of another incident when a trainee was shouted out for teaching a junior trainee during a busy period. Trainees had been called on the department tannoy to attend to patients or the board round, and reported numerous occasions when they had been shouted at by consultants in front of colleagues and patients. The visit team heard of further examples when trainees were being bullied, consultants shouting in public areas and doctors being undermined and demoralised on numerous		

		occasions. The trainees reported that they had all been in post in the ED during different periods, and these negative behaviours had occurred at other times other than during the winter pressures. The visit team asked the educational supervisors whether they recognised the alleged bullying culture, they stated that they did not think it was a problem, and did not recognise the behaviours. Notwithstanding the above some of the educational supervisors privately reported to the visit team that they had been on the receiving end of this behaviour. Furthermore, it was reported by some consultants that they had been present when colleagues had spoken to trainees in an undermining/ bullying manner. The names of the alleged culprits of this behaviour were passed to the Trust chief executive following the visit.		
6	6.3	**Staffing** The senior management team stated that they had struggled to recruit to consultant posts; however, the department had consistently achieved the London standard for hours of consultant cover in the ED. The Trust had also struggled with securing middle grade cover. The nurse staffing levels were generally good and above the core minimum. Once again, the Trust had difficulties in recruiting more senior nurses and this resulted in reliance on less experienced nurses. The nursing turnover rate had been at 34% but at the time of the visit, had dropped to 10-14%. The college tutor reported that since the death of their senior nurse manager, there had been a loss of continuity with staffing in the department with nurses from other parts of the hospital covering the position. The clinical director confirmed that there were 14 foundation year two (FY2) doctors, six general practice (GP) trainees, two specialty training (ST) EM trainees in years four (ST4) and five (ST5), a less than full time ST6 trainee, that had recently returned to the	Please provide your current proposals for further consultant recruitment and expansion including a planned timetable for this.	**Amber** Mandatory Requirement

		department, and two acute care common stem (ACCS) trainees. The remainder of the workforce was non-training grades. The trainees reported that consultants were available 16 hours per day, and they often stayed later than their rostered hours to help with the workload. The college tutor reported that the clinical director had responsibility for all operational aspects of the ED. There was no other person, e.g. a clinical lead who could run other elements of the department including day to day operations. There was also no designated lead for foundation trainees.		
6	6.4	**Rota** The clinical director reported that the trainees had complained about the rota, including the requirement to work seven nights in a row. The trainees were asked to review the rota, and amend it to improve. The new night rota set up by the trainees will be implemented in August 2015. This was understood to be consecutive three of four nights rather than seven nights. The trainees stated that the clinical director had asked trainees to review the rota set up. The trainees researched other ED rotas from London and developed an example rota which they had given to the clinical director as a suggestion for the department. The trainees confirmed that they were aware of a new rota being implemented in August 2015, but the rota had not yet been sent to the trainees, and they were unsure if the suggestions they provided had been implemented. The college tutor suggested that the trainees would benefit from a rota, which included specific sessions covering paediatrics, resuscitation, and also protected time for administration, to ensure they met all curriculum requirements.	Please provide the proposed new rotas for different grades of trainees joining the department in August 2015 and confirm that the relevant trainees have been involved in the preparation.	**Amber** Mandatory Requirement
6	6.5	**European Working Time Directive (EWTD)** The senior management team reported that a diary card monitoring exercise was starting on Monday 6 July 2015. The clinical director stated that he was not aware of there being a	Please confirm the plans for monitoring junior doctors' hours and ensure that they are repeated at least annually.	**Amber** Mandatory Requirement

		problem with trainee hours. The educational supervisors confirmed that they were aware of trainees being unhappy with and raising concerns regarding the rota. However they were not aware of the specific issues including potential non-compliance to EWTD and difficulties with undertaking a diary card exercise.		
6	6.6	**Study Leave** The clinical director stated that all trainees were allocated study leave and were released for training days. The department was unsure why they had received repeated red outliers in the General Medical Council National Training Survey (GMC NTS). The trainees stated that the rota had pre-allocated study leave. The rota and study leave days did not take into consideration training days such as the ACCS mandatory training days. Trainees commented that the study leave allocation was essentially their normal days off and looking at the rota, there was no extra off days.	Please clarify the current study leave policy for trainees and ensure that fixed study days are removed from the new trainee rotas from August 2015.	**Amber** Mandatory Requirement
6	6.7	**Teaching** The clinical director stated that there was three hours of teaching on a Wednesday morning. The teaching was linked to the ACCS and emergency medicine curricula. The trainees stated that the teaching sessions were variable in quality and attendance could be difficult. The teaching was provided by EM staff, and there was minimal influence from external departments which was a missed opportunity. The trainees reported that recently teaching sessions had been cancelled at short notice but if staff were available they would use the time to discuss issues within the department. A recent session involved discussions regarding the GMC NTS. Higher specialty trainees reported that during this session it was implied by the clinical director and some consultants that the foundation trainees did not know how to complete the survey or what they were answering, which resulted in the high quantity of red outliers. The foundation and core trainees had separate teaching to the	A review of the formal department training programme is required. This programme should be mapped against the various curricula and should involve teaching from members of the ED department and other hospital departments as appropriate.	**Amber** Mandatory Requirement

		higher trainees, and both had experienced problems specific to their teaching. Some of the educational supervisors stated that the teaching had been curriculum mapped, and that trainees were given the opportunity to provide feedback on sessions. The college tutor suggested it may be useful for trainees to have consultants from external departments, i.e. cardiology, respiratory medicine, intensive care medicine, to provide teaching on specific subjects.		
7	7.1	**Service Reconfigurations** The Trust chief executive explained that since the Barnet, Enfield and Haringey strategy had come into effect, there had been a planned increase in staffing levels in order to meet the increase in service volume and associated workload. The volume increase had broadly been in line with those predicted. There had been implications, with a higher numbers of patients being admitted by ambulance. This had created pressure on the ED. The ED had experienced problems with patient flows, discharging patients (either home or in to longer term care pathways) which had led to a lack of cubicle and bed availability in the ED. The clinical director stated that the planning of the workload with the local reconfigurations had been well predicted. There had been an increase in consultant numbers; there was nine whole time equivalent (WTE), of which six were substantive posts and three locums. It was acknowledged that this was below the minimum required by the Royal College of Emergency Medicine guidelines, and the Trust should be aiming for 16. The visit team heard that there was a budget for 14 consultants, and if during recruitment there were a higher number of suitable applicants they would appoint the full cohort of 16. The Trust was advertising for three consultants, with one having an interest/expertise in paediatrics.		

Good Practice	Contact	Brief for Sharing	Date
N/A			

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Other Actions (including actions to be taken by Health Education North Central and East London)	
Requirement	**Responsibility**
Health Education North Central and East London to confirm in writing to the Trust chief executive the names of the consultants alleged to have presented bullying and undermining behaviour. These have been passed to the Trust chief executive verbally and should be sent formally in writing.	Ian Bateman – Head of Pan-London Quality and Regulation
The clinical decision making of some middle grade doctors and consultant staff had been raised as a concern to the visit team. The visit team heard un triangulated concerns, the details of which should be sent formally in writing to the Trust chief executive, of the Trust to investigate formally.	Ian Bateman – Head of Pan-London Quality and Regulation
Overall the findings of this visit suggest a department that is lacking in strategic organisation and direction. This combined with a sense that there is a lack of effective leadership means that the department does not seem to operate effectively or efficiently. The visit team heard numerous anecdotal examples of where the lack of organisation, direction and leadership had subsequently impacted on the quality of not only education and training in the department, but also possible patient care. The Trust chief executive is strongly encouraged to commission a review of the department from the Royal College of Emergency Medicine, or another external department/body so as to be clear about the actions needed to move this department forwards. This report is to be shared with the NHS Trust Development Authority with a recommendation that they support an external review of the department followed by the provision of oversight in terms of turn around.	Trust chief executive Ian Bateman – Head of Pan-London Quality and Regulation

Information and reports provided to the team prior to the visit							
DME Annual Report	*No*	Regulator Reports/Data	*No*	LFG Reports	*No*	MEM minutes	*No*
GMC Survey - trainees	*Yes*	GMC Survey - trainers	*No*	Previous visit reports & action plans	*Yes*		
PVQs - trainees	*Yes*	PVQs - trainers	*No*	Result of school survey	*No*		

Signed	
By the Lead Visitor on behalf of the Visiting Team:	Dr Andrew Deaner
Date:	28 July 2015