Health Education England

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Pan-London Quality and Regulation Unit

Imperial College Healthcare NHS Trust
Emergency Medicine
Acute Care Common Stem
Specialty Focused Visit

Quality Visit Report

2 November 2015

Final Report

THE NHS CONSTITUTION
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Visit Details	
Trust	Imperial College Healthcare NHS Trust – St. Mary's Hospital
Date of visit	2 November 2015
Background to visit	The visit team was focused on the acute care common stem (ACCS) and emergency medicine training available on the St. Mary's Hospital site. The General Medical Council National Training Survey (GMC NTS) results for 2015 and the local information gathered by the Head of the London School for Emergency Medicine suggested the need for a review of the training environment at St. Mary's Hospital. The Care Quality Commission (CQC) visit in September 2014 highlighted areas of improvement for the St. Mary's Hospital's emergency department for the use of up-to-date clinical guidelines, handover, and patient flow. The visit team wanted to explore these areas for patient safety concerns but also if this had affected the training experience of the ACCS trainees who rotated into the emergency department and the higher trainees within emergency medicine. There had been reports of on-going bullying and undermining issues within the emergency medicine department and there had been evidence that this had been discussed at local faculty groups (LFGs). The progress and sustainability of the solutions put in place and the Trust's approach to bullying and undermining needed to be assessed by the visit team. The training environment needed to be assessed in key areas flagged up by the GMC NTS: trainees' workload, clinical supervision, the supportive environment, availability of teaching programmes, and the ability of trainees to attain curriculum competencies. There had been on-going issues regarding core trainees in the emergency medicine being placed into positions, especially at night, that were outside of the trainees' competencies which the visit team felt warranted a visit to the Trust.
Visit summary and outcomes	The visit team would like to thank all who attended the sessions, and acknowledge the amount of work undertaken by the Trust to ensure the visit was well attended and ran efficiently. The visit team met with the senior management team initially, followed by the ACCS faculty leads for all stems of ACCS, which included intensive care medicine (ICM), emergency medicine, acute medicine and anaesthetics and the Chief of Service and college tutor for emergency medicine. This meeting was followed by the ACCS trainees, which included core training (CT) and specialty training (ST) trainees: Specialty ACCS CT1 and ST1 trainees, CT2 and ST2 trainees and core emergency medicine ST3 trainees. The ACCS trainees' placements were in emergency medicine, anaesthetics, ICM, and acute medicine. This was followed by a session where the visit team met these trainees' educational supervisors and clinical supervisors. The afternoon was focused on meeting higher trainees in emergency medicine, of which we met two, followed by the education and clinical supervisors for emergency medicine. Overall, the training environment was found to be a positive one with the majority of trainees recommending St Mary's Hospital for friends and family to be treated at and colleagues to train at. The only exception was the ACCS acute medicine posts, which were found to be suboptimal for meeting training competences. All trainees had concerns regarding the volume of training exposure to trauma cases to meet curricula requirements and higher trainees in emergency medicine had concerns on meeting curriculum requirements for paediatric cases. The complexity of the Trusts three acute site structure combined with unclear clinical pathways and processes meant that there was a lack of clarity on the roles and responsibilities of trainees in referring patients to specialties. Sub-optimal cross-site acute patient transfer protocols and responsibilities were concerning. Other areas for improvement included: the lack of clarity around the management and administration of the ICM rota, the lack of clarity regarding the ST3 core trainee role in the emergency medicine department, the feedback and dissemination of serious incidents should be implemented in the manner of the good practice the visit team found for the ICM department, and separate teaching for ACCS trainees should also be implemented. .

	Other areas that were working well included, the use of local faculty groups and the use of the trainee liaison role within anaesthetics, but there needed to be the continuation and development of LFGs in ACCS and acute medicine. The visit team appreciated the combined teaching of medicine and emergency medicine higher trainees to facilitate greater understanding between the different departments. Trust should be commended for the proactive approach taken for bullying and undermining, where there had been obvious progress made, however the Trust should think about creating a conduit for trainees to feedback issues that does not involve a consultant or senior clinical colleague within a given specialty team. The instigation of the optional Basic Course for core trainees starting in ICM should be commended and the visit team recommends all trainees starting in ICM be facilitated to attend this course.

Visit team			
Lead Visitor	Dr Chris Lacy, Interim Head of School for Emergency Medicine	**Royal College of Emergency Medicine Representative**	Dr Angela Feazey, Training Programme Director Health Education Kent, Surrey and Sussex
Trust Liaison Dean	Dr Chandi Vellodi, Trust Liaison Dean	**External Representative**	Dr Nidhi Vaid, Consultant Acute Physician, London North West Healthcare NHS Trust
External Representative	Dr Duncan Brooke, Foundation Training Programme Director, South Thames Foundation School	**Trainee Representative**	Dr Oliver Mizzi, Trainee Representative
Lay Member	Kate Rivett, Lay Representative	**Trainee Representative**	Dr Matthew Edwards, Trainee Representative
Visit Officer	Lizzie Cannon, Quality and Visits Officer		

Findings			
Ref	**Findings**	**Action and Evidence Required.** **Full details on Action Plan**	**RAG rating of action**
GMC Theme 1) Learning environment and culture			
EM1.1	**Patient safety** The visit team heard that the acute medicine firms at St Mary's Hospital held twice-daily ward rounds. However, the clinical leads stated that at Charing Cross Hospital this differed as there was no dedicated acute medicine consultant, resulting in a twice, weekly ward round. However, instead of seeing every acute medicine patient every day, a consultant only saw acute medicine patients based on the acuity of their condition. There was a twice-daily board round where the clinician of the week would review all the patients. This was also reported in a separate, simultaneous Specialty Focused Visit for core medicine where it was raised as an Immediate		

	Mandatory Requirement (IMR). The ACCS trainees in ICM confirmed that unlike at the Charing Cross Hospital site, the trainees at St Mary's Hospital did not undertake any roles, which they were not trained to do, such as nursing patients as part of the Charing Cross Hospital escalation policy. One ACCS trainee did state that they fulfilled a locum shift as an anesthetist on the intensive therapy unit (ITU) at Charing Cross Hospital, which resulted in nursing patients. A Specialty Focused Visit to ICM at Charing Cross was conducted on 3 November 2015 where this issue was raised, and an IMR issued to the Trust. The visit team was pleased to hear that the St Mary's Hospital ICM rota always had a tier with clinicians who had dedicated airway skills; this was also a requirement for any locum doctors that covered this tier on the ICM rota. They also stated that the anaesthetic rota was separate from the ICM rota and had separate anaesthetic cover for the ITU increasing the number of doctors with dedicated airway skills. The ACCS trainees in emergency medicine stated that there were a lack of monitors and echocardiogram (ECGs) machines within the emergency department. At the time of the visit the trainees stated that there was only one ECG machine for the entire emergency department. The visit team heard that the department had received four new ECG machines three weeks before the visit in November 2015 but they had now all disappeared. The higher trainees in emergency medicine corroborated this and stated that they did not know if anyone was monitoring this or how it happened. They also reported that the leads for these machines were frequently missing. The consultants highlighted that because so many patients were transferred out of the emergency department to other wards or sites the monitors and ECG machines were taken with them and never returned. The consultants did not have a solution for this problem. The ACCS trainees in ICM, anaesthetics and emergency medicine would be happy for their friends and family to be treated at St Mary's Hospital, however there were reservations for ACCS trainees in acute medicine who stated that although they deemed it safe for patients, it was not the optimum. The higher trainees in emergency medicine reported that sometimes they were not particularly confident in the quality of the streaming that occurred when referring patients to the Urgent Care Centre (UCC). They stated that this was because of a pressure to move patients from the emergency department to hit the four hour quota and because there was a shortage of beds on other wards. However, they did feel that most sick patients were correctly identified and seen in the emergency department rather the UCC. The visit team also heard from the higher trainees in emergency medicine that there were no protocols for referring patients onto the ambulatory care unit, (ACU). The ACU was open form 8am to 8pm and was predominantly for patients who were safe to go home that day but needed a little more medical input before doing so. However, if the patients on the ACU were not discharged then they were moved back into the emergency department. The ACU was run by emergency medicine consultants but was not integrated into the emergency medicine rota. The emergency medicine consultants stated that the ACU wad staffed by an emergency medicine consultant in	The Trust is required to provide a summary of the number of monitors and ECG machines available in the emergency department and proposals as to how the Trust plans to maintain adequate equipment levels in the department at all times.	**Amber** Mandatory requirement

	the afternoon, a core medical trainee (CMT) or military ACCS acute medicine trainee and a locum emergency medicine higher grade rather than emergency medicine trainees. The higher trainees in emergency medicine also stated that they experienced difficulties in referring patients to specialities because of the complexity of the Trust's acute care model with three acute sites (St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital sites). This was made worse when a patient had multiple co-morbidities and needed the input of several specialties (e.g. renal medicine, cardiology, gastroenterology), with no clear protocol or policy in place to provide clarity. The higher trainees in emergency medicine felt they often faced the dilemma of 'which specialty' and 'which site' to refer patients to, especially acute medical patients. They stated there was no single point to refer medically unwell patients to, and that the acceptance of patients by the various medical specialties depended on who was on acute take for the different specialties that day. The higher emergency medicine trainees stated they experienced difficulties in transferring these patients across the three acute sites in the Trust. The trainees stated that they had already raised the transfer issue regarding chest pain patients, as this was the most difficult; however, they had received no feedback. The higher trainees stated that although they considered the transfer and referral of patients was safe, but it could be improved, by clarifying which patients required medical or nursing escorts during transfer and who accompanied patients. An anaesthetist always accompanied those patients requiring airway support but it was unclear who accompanied other sick patients. The emergency medicine consultants stated that there were pathways on the intranet available to trainees and the trainees had been made aware at induction. However, the consultants recognised that especially with an increasingly different case mix due to the changes in North West London there was a need to refresh the pathways and the protocols. The higher emergency medicine trainees reported that the inception of the Cerner electronic note taking system had led to difficulties in accessing old patient records especially clinic notes. This can lead to difficulties maintaining continuity of patient care. Higher EM trainees felt the system was useful but time consuming. They pointed out that the Urgent Care Centre (UCC) did not use the system and this lead to difficulties when patients were transferred back to the emergency department. The Chief Executive outlined in her presentation to the visitors that the Cerner electronic note taking system was implemented in Easter 2014 and has been rolled out in phases. Electronic documentation and e-prescribing are yet to be implemented and she acknowledged the Trust was aware this might cause some difficulties. The higher trainees in emergency medicine stated that although the emergency medicine was respected, medical teams were still resistant to give beds to patients in the emergency medicine department.	The Trust is to provide clarification of the referral protocol for acute patients to acute specialties across all three acute sites, and provide evidence of how this information is disseminated to all trainees in all specialties involved in providing acute care (emergency medicine and acute care specialties). The protocol should include the mechanism available to trainees to aid decision making when a complex patient requires the input of multiple specialties. Escalation processes must also be clearly developed, including consultant to consultant referrals if needed. The Trust is required to provide the cross-site transfer protocols for acute patients confirming responsibilities for clinical care, clarification of which patients require escorts, what level of escort is provided (either nursing or medical), and which specialty provides these escorts.	**Amber** Mandatory requirement **Amber** Mandatory requirement
EM1.2	**Serious incidents and professional duty of candour** The ACCS trainees reported that there was minimal emphasis on clinical governance and		

	dissemination of findings. The Trust was perceived by the trainees as viewing clinical governance as a tick box exercise. All of the trainees knew how to submit a Datix form but none had received any feedback. The trainees concluded that this was because the feedback was not disseminated via the NHS email addresses but via the allocated Trust Imperial emails that few trainees stated they used regularly. The consultants were only aware that ACCS trainees transferring from Ealing Hospital to complete their ICM posts could not read the reports due to not having an Imperial email account and were working to roll these out to all trainees. However, they were not aware that the majority of trainees did not use the Trust email. The higher trainees in emergency medicine stated that they knew how to fill out a Datix form for serious incidents but there was no comprehension of how feedback would be received. Results from audits were disseminated via emails, and themes from complaints with clinical relevance were sent by email once a month. Core emergency medicine ST3 trainees reported having seen one clinical governance email. The visit team found good practice within the ICM department in regards to the feedback of serious incidents that the visit team feels should be implemented in the other specialties. The visit team was told by the ICM consultants that there was a weekly meeting where any Datix returns were shared with the trainees and the clinical supervisors. This was followed up by a weekly safety newsletter and, once a quarter all members of the ITU were sent copies of the final reports on the serious incidents. ICM trainees were also all supported through the process if they had reported a serious incident.	The department must ensure that there is an effective mechanism of including trainees in clinical governance activities including learning from incidents.	**Amber** Mandatory requirement
EM1.3	**Appropriate level of clinical supervision** The General Medical Council National Training Survey (GMC NTS) results for 2015 in emergency medicine showed a red outlier for clinical supervision out of hours. The consultants stated that they had discussed this at the local faculty group, as they could not identify the lack of supervision out of hours, or that the trainees felt incompetent people were supervising them. The emergency medicine consultants stated that since May 2015, five new consultants had been appointed, which meant there was consultant presence in the emergency department until midnight on weekdays, and 12 hours per day on weekends, after which there was a consultant on call. The emergency medicine consultants stated that there was close to 24-hour higher training grade or equivalent cover in the emergency department. However, they did state that if the higher grade is required in the resuscitation area there may be a lack of higher-grade cover in the rest of the emergency department, but the new second tier registrar rota had ensured that there was middle grade cover. The ACCS trainees in emergency medicine corroborated this. They stated that within normal hours, there was always either a consultant or a higher-grade trainee, or equivalent trust doctor, however at nights they felt a lack of support if one of the higher-grade doctors was called away to the resuscitation area and there were not enough higher grades on the shop floor due to rota		

	gaps. The trainees reported that this had been a problem in August 2015 while there was only one higher grade on the night rota; however, this had been improved in October 2015 when two higher-grade doctors were placed on the emergency medicine rota at night. The ACCS trainees who had rotated through the emergency department stated that there was on average a 20 per cent use of middle grade locums during the night. The trainees reported that they were confident in the quality of the higher-grade locums and that the locums were normally the same people. The trainees felt they received good support and supervision from the locums. The higher trainees in emergency medicine also stated that they were happy with the quality of the locums. The emergency department trainers informed the visit team that there were normally eight middle grades on the 'senior registrar' rota, however, currently there were 2 vacancies requiring locum cover. They confirmed that staffing shortages at a higher trainee level had contributed to this. The ACCS trainees currently placed in the emergency department stated that there was consultant cover until 11.30 at night, and that the consultants were very supportive. After midnight, the trainees stated that there was a consultant present as trauma team leader (TTL) who they were not supposed to call for support but if trainees did call, was usually approachable and supportive. However, they reported approximately 60% of the TTL consultants were locums from outside the Trust and from a variety of specialties. In previous visits, the staffing of the Urgent Care Centre (UCC) and minors area had been an issue. The visit team heard that during the daytime the UCC was staffed by one foundation year two doctor, one nurse, one consultant and a consultant in general practice who was responsible for the paediatric cases. After 5pm the UCC was staffed by the foundation year two doctor, a nurse and a higher grade doctor is present until 11.30pm. After 11.30pm until 8am there was only the foundation doctor in the UCC. The trainees stated that this was discussed as an issue at an LFG and it was decided to move the UCC from midnight to 8am into the emergency department. The ACCS trainees stated that when on shift in the UCC until 11.30pm it was difficult to find a senior colleague to come down and review a patient if needed but support was more accessible after the UCC was moved to the emergency department at midnight. However, its location in the emergency department between these hours was still not ideal, because it was hidden around a corner. The higher trainees in emergency medicine stated that if emergency medicine core ST3 trainees were on the night shift, the higher trainees were responsible for the clinical supervision. This would sometimes result in the ST3 leading the department or managing the resuscitation area, while the higher trainee supervised, which the higher trainees thought was an excellent training opportunity for both training grades. The visit team heard that the ACCS trainees in ICM received excellent levels of clinical supervision and support with an approachable and supportive consultant body.	The Trust is required to monitor the supervision levels of the UCC and ensure that adequate support is available during the night and day.	**Amber** Mandatory requirement
EM1.4	**Responsibilities for patient care appropriate for stage of education and training**	The Trust is required to consider that the	

	The visit team was concerned to hear that the core training grade three (ST3) trainees in emergency medicine were referred to by the nursing staff and foundation doctors as 'registrar' grade trainees, confusing them with higher emergency medicine trainees (ST4 – ST6). The emergency department clinical and faculty leads confirmed that the introduction of a new rota in the last month had created a second tier 'registrar' rota which was intended to provide additional night over. They felt this gave trainees valuable experience in acting up on nights while supervised by a higher trainee. The CT3 emergency medicine trainees told the visit team that they had not been asked to complete any tasks beyond the competencies of their training grade, and confirmed that they were always supervised on nights by a higher emergency medicine trainee or a locum middle grade. They reported that they were referred to as 'registrars' and that this lead to confusion with nursing staff and foundation trainees who did not appreciate they were core trainees. The visit team were concerned that ST3 core trainees would be inadvertently assumed on occasions to have the competences of an emergency medicine higher trainee.	naming of core ST3 emergency trainees as 'registrars' may cause confusion as to the level of competence and responsibilities these trainees are expected to have. The Trust is required to clarify the roles and responsibilities of the ST3 emergency medicine trainee to all staff within the emergency medicine department. This could be evidenced through a roles and responsibilities policy, which is accessible to all staff via the intranet. The LFG minutes could also provide evidence that this has been discussed and clarified. The visit team requests the Trust consider adopting a different nomenclature for this grade (e.g. senior core trainee) to indicate that these are core trainees and do not have the full set of ST1 to ST3 core emergency medicine competences or supervisory skills of a higher grade trainee.	**Amber** Mandatory requirement
EM1.5	**Rotas** The visit team heard that from November 2014 to February 2015 there had been three gaps on the ICM rota for the St. Mary's Hospital site, which had inhibited trainees' training and educational opportunities, but the gaps had now been filled. The consultants stated that they could find out there would be unfilled training posts in the forthcoming rota period very late on, which made it hard to fill them in time. The ACCS trainees in ICM stated that there were issues with the ICM rota; in particular, there were considerable problems with rota organisation and management. The visit team heard that on a daily basis the ICM rota did not match up with who was actually on the shop floor and the trainees had resorted to doing the rota themselves. The trainees did state that the rota was now reasonably well staffed, but the trainees received rotas late. One trainee was expected to start on a night shift and this was only communicated to them on the induction day. The ACCS trainees in ICM stated that there was no channel for them to escalate and address the rota issue. The visit team heard from the ACCS trainees in anaesthetics that they were happy with the rotas and there were no problems to report. The ACCS trainees in emergency medicine appreciated the recent change to a rolling rota, with trainees working four to five days on which made it easy to plan annual leave and attend regular, weekly teaching. They commended the excellent emergency department rota coordinator. The new emergency department rota gave ACCS trainees an increased number of shifts in the	The ICM rota management at St. Mary's Hospital needs to be reviewed to ensure good management and timely distribution of rotas to all staff.	**Amber** Mandatory requirement

	resuscitation area. This issue had been previously raised in the LFG. The visit team heard that the core ACCS trainees were supposed to have allocated shifts within the paediatric section of the emergency department but there were a very limited number of shifts within paediatrics. One ACCS trainee reported receiving one paediatric emergency medicine shift in three months. The higher emergency medicine trainees reported a similar difficulty with the allocation of shifts in the paediatric area. They rarely got more than one shift in three months and stated that they relied on 'double ups' on the rota to free them to go to the paediatric area. The visit team heard from the emergency medicine higher trainees that the rota had changed in October 2015, with a two-tier system being implemented. The higher trainees stated that the change in rota had been influenced by the trainees' concerns that previously there had only been one higher training grade on the shop floor at night. The visit team heard that the new two-tier rota meant that there was a specialty training core grade three trainee (ST3) alongside a higher trainee of ST grade four to six. This ensured that there was always a higher-grade trainee or equivalent in the emergency department 24/7. The higher trainees also stated that the new rotas were planned until April 2016, which meant they could plan leave easily. They also reported that the change to a 4:3 split in consecutive nights was far preferable to their previous rota of single nights and that their days shifts had been grouped more appropriately.	The Trust is required to confirm that ACCS trainees in EM are appropriately rostered to the paediatric area to allow trainees to acquire and maintain the required paediatric emergency medicine competences. This can be provided in the form of rotas or workload analysis of the number of paediatric patients seen by existing trainees over a 3 month period.	**Amber** Mandatory requirement
EM1.6	**Induction** The higher emergency medicine trainees stated that there was a good local induction, which covered everything, including the role of the CDU, the CDU admission criteria and protocols. The visit team heard from all ACCS trainees that the Trust induction had been poor but that the local inductions had been good. Higher trainees mentioned that clarity on cross-site transfer protocols and specialty admission criteria were lacking in trust induction.	The Trust is to provide a summary of the topics covered in the Trust induction programme, and the sources of information available to new starters with respect to cross-site admission criteria for all specialty teams and the renewed cross-site transfer policies.	**Amber** Mandatory requirement
EM1.7	**Protected time for learning and organised educational sessions** The visit team heard from the consultants that there was no focused teaching for ACCS trainees in acute medicine because there was no dedicated acute physician at the St. Mary's Hospital site. The ACCS trainees in acute medicine corroborated this stating that there was no regular acute medicine teaching and even if there were, the rotas would not allow the trainees to attend. The ACCS trainees reported that there was no separate teaching for ACCS trainees and at the time of the visit they were sharing teaching with the foundation year two doctors which was not adequate or specific to the trainees' learning needs. The ST3 emergency medicine trainees stated that they were able to attend the regular teaching, which was held once every two weeks on Wednesday afternoons. However it was directed towards higher trainees and incorporated a lot of management topics and was not necessarily	The Trust is required to ensure that ACCS trainees in each specialty (emergency medicine, acute medicine, anaesthetics and intensive care) are provided with weekly, bleep-free teaching that is focused to the training needs of the ACCS trainees. Similarly, Core ST3 emergency medicine trainees are required to have appropriate protected training addressing the ST3 emergency medicine curriculum needs other than paediatric emergency medicine. These requirements should be evidenced	**Amber** Mandatory requirement

	focused on the ST3 core curriculum. The CT3 trainees undertaking training in paediatric emergency medicine (PEM) stated that there was pure paediatric emergency medicine teaching every Thursday and could be good quality. The variable quality was because it was self-organised by the trainees, with no consultant leading teaching. The visit team heard from the consultants that the Basic Course was offered to ACCS trainees entering ICM who have not yet undertaken the six months in anaesthetics to increase their skills and confidence. The ACCS trainees stated that the basic course was available at Charing Cross Hospital and was run twice a year. They stated that it was accessible and optional, but that they were not at a disadvantage if they had not attended the course. There was an understanding within the Trust that airway skills in critical care were not the ACCS trainees' responsibility. The visit team also heard the ACCS trainees in anaesthetics all undertook the novice anesthetist course, which was geared to acquiring practical skills rather than the anaesthetic post-graduate exams. The course was a five-day course with a mixture of simulation and didactic training. The consultants stated that this course was run several times per year and that they could send trainees to The Royal Marsden NHS Foundation Trust course if needed. The consultants stated that all ACCS trainees, regardless of parent specialty had the opportunity to partake in simulation training and the novice anesthetist course. All the ACCS trainees confirmed that they had undertaken the novice anesthetist course and this was a mandatory requirement. The higher trainees in emergency medicine stated that there was no emphasis on specific trauma teaching. The visit team heard that there were Trust trauma meetings held every Thursday at which several different trauma cases were discussed, but the higher trainees could only attend if presenting because of the busy workload. They stated that they were able to attend local emergency medicine higher teaching that was held once every two weeks and would commonly be consultant led. The higher trainees in emergency medicine also stated that there was regular teaching with trainees from other medical specialties that helped to build relationships between the departments. This in particular helped to clarify misunderstandings over the appropriateness of referrals.	through a teaching plan for the next six months and a register to monitor attendance. The trust is required to consider how trauma teaching could be incorporated into the ACCS and higher emergency medicine local teaching programmes.	**Amber** Mandatory requirement
GMC Theme 2) Educational governance and leadership			
EM2.1	**Impact of service design on learners and educators** The visit team heard from the senior management that there were plans to close the emergency department at Charing Cross Hospital. The emergency medicine consultants at St Mary's stated that this closure, together with other Health Education north West London (HENWL) sector changes and the continuing increases in emergency department attendances, would necessitate		

	the need for further increases in consultant numbers at St. Mary's Hospital. The faculty leads for emergency medicine confirmed that consultant numbers on the St Marys site had already expanded to 14.1 whole time equivalent (WTE) including 3.1 WTE consultants in paediatric emergency medicine in the last two years. The consultants stated that that if there was only one emergency department in the Trust then they aimed to provide 24/7 emergency medicine consultant cover, and a multi-professional major trauma team leader (TTL) rota that included consultants in anaesthetics, trauma surgery and emergency medicine. The visit team commended the progress the emergency medicine department had made by nearly trebling the number of consultants within two years and supported the increasing of numbers within the emergency medicine and paediatric emergency medicine.		
EM2.2	**Appropriate system for raising concerns about education and training within the organisation** The visit team heard that there had been a sustained use of regular local faculty group (LFG) meetings for emergency medicine, where trainees reported they felt comfortable to discuss training and educational issues. The minutes of the meetings had been distributed to the trainees. The ACCS trainees within emergency medicine stated that they were also invited to attend the LFG despite having a different specialty-training post, such as anaesthetics, intensive care medicine or acute medicine. The visit team heard that there had been only one ACCS LFG meeting to date, but that this had not been well attended or focused on training needs. It was also reported that there were LFGs dedicated to training in all ACCS specialties except for acute medicine, however there was an acute medicine LFG that ACCS trainees were able to attend. The anaesthetic ACCS LFG demonstrated good practice by appointing a liaison trainee who met with the trainees in a closed meeting before the LFG to feedback any concerns the trainees may have had regarding training. The liaison trainee would then occasionally lead the LFG. The clinical leads stated that there were resulting action plans from the LFGs and these were fed up to the divisional management committee with education being the first item on the agenda, integrating educational issues with service needs.	The Trust is required to continue the progress made regarding local faculty groups and set up a local faculty group for ACCS acute medicine. All ACCS trainees who are working within acute medicine at the Trust to be invited to attend, along with all acute medicine consultants. This should be evidenced through minutes and a register. The Trust is required to ensure that the recently formed Trust ACCS LFG is continued and this should be evidenced through minutes and an attendance register over a six month period.	**Amber** Mandatory requirement
EM2.3	**Systems to manage learners' progression** The visit team heard from the clinical leads that the ACCS trainees were given an educational supervisor from the trainee's parent specialty. This designated educational supervisor would not change even if the trainee rotated into a different ACCS specialty within the Trust. This allowed a consistent person from the trainees' parent specialty to track the trainee's progression. The consultants stated that ACCS trainees from Ealing Hospital (part of London North West Healthcare NHS Trust) who received intensive care medical training at Imperial College Healthcare NHS Trust would perhaps not be as supported. The visit team heard that the		

	consultants were working to bolster the support give to these trainees. The ACCS trainees reported that they all met with the assigned educational supervisor and felt supported by them. This included ACCS trainees from Ealing Hospital. The visit team heard that a military consultant within the department was responsible for the progression of the military core trainees. The military core trainees were unsure as to whether the civilian training programme director (TPD) was responsible for the training or the military trainees.	The Trust is required to clarify with the military educational supervisor which TPD is overseeing the military ACCS training programme at St Mary's Hospital and notify the military trainees appropriately.	**Green** Recommendation
EM2.4	**Organisation to ensure access to a named clinical supervisor** The visit team heard from the consultants that the ACCS trainees were provided with a clinical supervisor, which was separate from the trainees' overall parent specialty educational supervisor unless in the same specialty. The visit team stated that it was beneficial to have two separate people as the ACCS educational and clinical supervisor to add an extra conduit for trainees to feedback through, and to support trainees in their career planning.		
GMC Theme 3) Supporting learners			
EM3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The visit team was pleased to hear that the bullying and undermining behaviour in the respiratory medicine firm had been dealt with robustly. The behaviour was raised as a disciplinary issue and the consultant in question was removed as a clinical supervisor with suitable consultants taking on these responsibilities. Another consultant now supervised the consultant's ward rounds. It was also reported that a lot of work had been done to develop how the firm was managed. The consultants stated that they had had long discussions on how to address bullying and undermining, which had been flagged in the 2015 GMC NTS as a red outlier. The consultants had engaged with John Launer and his team to develop how to have conversations with trainees regarding bullying and undermining. They also stated that they had used consultants external to the departments to allow the trainees to report any untoward behaviour. The consultants stated that the post-graduate medical education team had organised local training on how run a LFG and use LFGs as a tool for combatting bullying and undermining behaviour. There were mixed views from the consultant body regarding the support given to trainees by the post-graduate medical education team, which was dependent on which division the ACCS stem was located within. The emergency medicine and acute medicine consultants stated that the director of medical education (DME) for this division, Megan Griffiths, provided very good support for trainees. She would meet with them outside of the LFGs with the trainees to discuss and specifically solve issues. The anaesthetic and ICM consultants stated that the DME for the surgical division was not as engaged. However, because of the large consultant body, separate educational and clinical		

	supervisors for trainees and the regular use of LFGs combined with the trainee liaison role, the consultants felt that there were an adequate number of conduits for trainees to use to report bullying and undermining behaviour. The ACCS trainees in emergency medicine reported previous bullying and undermining behaviour by one consultant (unnamed at the visit) in emergency medicine, who, during ward rounds would pick on one trainee for the entirety of the six months, which brought the trainee close to tears most mornings. The trainees stated that this was in 2014, and although they had not heard, witnessed or experienced any bullying and undermining behaviour since, and they knew that the consultant had been spoken too, they did not know if anything had changed. Current ACCS trainees in emergency medicine reported no episodes of consultant bullying and undermining behaviour. The ACCS trainees in emergency medicine stated that they were questioned heavily at the morning handover by the higher-grade doctors regarding the clinical decisions made on the night shift. They felt this did not provide an open or educational environment. The emergency medicine trainees held a different view, stating that the teaching rounds were very good especially for the lower grade doctors. The higher trainees also stated that it was a very supportive department. The ST3 trainees in emergency medicine stated that although the emergency department was generally more relaxed about the four-hour target there had been a number of times where the ST3 trainees had had to speak to the nurses about the way they were pressuring the foundation doctors to meet the target which they had perceived as undermining behaviour. The ACCS trainees the visit team met with stated that they had all been informed at induction that there was bullying and undermining at the Trust, that the senior management was aware of this and that if the trainees experienced or witnessed any such behaviour they should report it. However some trainees were unaware of who to escalate such behaviour to and one trainee had been undermined and had not known who to go to for support, other trainees stated that they felt comfortable going to the assigned educational supervisor. The senior management team indicated that the joint emergency medicine and acute medicine higher trainee teaching sessions had led to robust discussions about bullying behaviour that arose over emergency department referrals that had successfully addressed this issue.		
EM3.2	**Academic opportunities** The visit team heard from the acute medicine consultants that they engaged the ACCS trainees in acute medicine in quality improvement projects (QIPs) to help solve problems with trainee input. The higher trainees in emergency medicine stated that there were opportunities for audits if the trainee showed an interest.		
EM3.3	**Access to study leave** The anaesthetic consultants stated that the ACCS trainees in anaesthetics were supernumerary which ensured the ACCS trainees could always attend training days. The ACCS trainees in		

	anaesthetics confirmed this statement, reporting that they had never experienced any problems receiving study leave and attending training days. The ICM consultants stated that there had been previous issues with the rota, with three unfilled slots on the rota from November 2014 to February 2015. This had inhibited the ACCS trainees in ICM attending study days, however the rota had been changed and the consultants stated that trainees were able to attend teaching sessions. The ACCS trainees in ICM stated that even with a poorly managed rota they were able to attend study days and teaching, but they perceived that there was no thought as to who would be left on the shop floor. The visit team heard from an acute medicine consultant that the ACCS trainees experienced no problems receiving study leave for ACCS acute medicine training days. However, the ACCS trainees in acute medicine, in the respiratory post, reported that they were not able to attend the pan-London ACCS training days due to their rota. The other ACCS trainees the visit team met stated that they could attend training days and the ACCS trainees in emergency medicine were able to attend the monthly Pan London emergency medicine training days too. The ACCS trainees in emergency medicine stated that the rota coordinator was very proactive and all trainees had been give the study leave they had asked for. The higher trainees in emergency medicine corroborated this view stating that they could attend the one day regional, formal teaching once a fortnight.	The Trust is required to ensure that all ACCS trainees in acute medicine are given appropriate study leave to attend regional training days as required by their specialty school. This requirement can be monitored by a trainee survey of the training days attended by all ACCS trainees in acute medicine during the first 6-month post from August 2015.	**Amber** Mandatory requirement
GMC Theme 4) Supporting educators			
EM4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team heard from the consultants in emergency medicine that there were approximately 14.1 whole time equivalent consultants working in the St. Mary's Hospital emergency medicine department. All consultants had separate job plans and an adequate number of special programmed activities (SPAs) for the non-clinical responsibilities they undertook, with 0.25SPAs per trainee, per educational supervisor, to a maximum of 0.5 SPAs. The anaesthetic college tutor reported receiving an additional 1 SPA to support this role and the emergency medicine specialty lead and TPD felt they had appropriate provision within the emergency medicine team job plan to support their roles.		
GMC Theme 5) Developing and implementing curricula and assessments			
EM5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** **ACCS Acute Medicine** The visit team heard that there were three posts allocated to ACCS trainees within the acute medicine firm based structure; the respiratory post, the acute medicine post, which worked		

	between ambulatory care and the acute take, and the firm five post which the consultants described as a general medicine firm. This post included respiratory, rheumatology and medical pharmacology with the acute take one week out of five. The consultants stated that the acute medicine model had retained the firm based structure for continuity to training and patient care. The consultants stated that this meant that was no acute medicine rota. The consultants stated that they had received good feedback from trainees prior to the visit in November 2015, regarding the core training post that rotated between ambulatory care and the acute take. The trainees report that this acute firm gave them an opportunity to do acute take and ambulatory care but had a floating week where they had less to do. This was useful for attending clinics of their choice or for exam preparation. The ACCS trainees reported they were well supported on the respiratory firm and had an opportunity to do many of the procedures required by the ACCS curriculum. However the firm five post, had received less positive feedback with trainees reporting that they would appreciate less time on the wards, to allow for training in other areas. The visit team found that there was an inequitable allocation of acute medicine training opportunities within the three posts for ACCS trainees in acute medicine and as a result believed that two out of the three posts were inadequate for ACCS acute medicine training. This conclusion was based on the statements reported by the ACCS trainees in the acute medicine posts who stated that the only post that was deemed to be good for training, if not for acute medicine was the respiratory post. The trainees stated that one of the problems was that there were no acute firms allocated to the acute ward, which resulted in all the acute medicine patients being distributed amongst the departments. This combined with the firm five post where trainees are asked to work on the Thistle Ward which has many outlier patients which are not acute patients. None of the ACCS trainees would recommend St. Mary's hospital for acute medicine training, because it was a struggle to meet any acute medicine competencies unless on the acute take, which was rare. **ACCS Emergency Medicine** The ACCS trainees in emergency medicine stated that there got little exposure to minor cases because they were infrequently rostered into the UCC or minors area. When the trainees were in the UCC, they stated that a consultant was always available to complete workplace-based assessments (WPBAs). The visit team heard that the ACCS trainees in emergency medicine were receiving limited exposure to the resuscitation area, however the trainees stated they fed these concerns back to the trainers and they now had an allocated daytime shift within the resuscitation area. The core ST3 trainees in emergency medicine did however, state that they were no longer confident regarding anaesthetic skills and felt they had deskilled.	The Trust is required to undertake a review of the training opportunities provided for ACCS trainees in acute medicine as a matter of urgency. This finding is to be discussed with the Head of School for Medicine following the second day of the Trust visit to assess core medical training. The trust is required to review the rostering of ACCS trainees to the UCC or minors area and ensure that shifts allocated to these areas occur regularly to allow trainees to meet curriculum requirements. This could be evidenced by a trainee survey of the percentage of shifts in the UCC over a 3-month period and through LFG minutes to address this issue. The Trust is required to review the educational opportunities available through board rounds in the emergency department. This can be evidenced through discussions held with trainers and trainees in the emergency medicine/ACCS LFGs and monitoring of implementation of action points arising.	**Amber** Mandatory requirement **Amber** Mandatory requirement **Amber** Mandatory requirement

	The ACCS trainees in emergency medicine stated that the department was very busy which left little time for formal learning, but with the new rota, this was improving. The trainees stated that they would like to see more educational emphasis on the ward board rounds, with more associated teaching. The emergency medicine consultants stated that ACCS trainees in emergency medicine could also partake in trauma calls, if they were trained in advanced trauma life support (ATLS). **ACCS ICM and ACCS anaesthetics** The ACCS trainees in both ICM and anaesthetics were very happy with the training opportunities they received and would recommend the post. **Emergency medicine – Higher training** The higher trainees in emergency medicine stated that there was a lack of trauma exposure. They stated that higher trainees were only allowed to complete the primary survey for trauma patients and then the trauma team lead would take over. The higher trainees were not allowed to lead the trauma, unless they had completed the trauma team leader course, which they had been offered. This was not normal practice the trainees had experienced before and they would like more trauma experience. However, the emergency medicine consultants stated that higher trainees would be able to lead on trauma after they had seen three and done three trauma cases and then was signed off by the trauma lead. The visit team suggests that this should be clarified to the trainees. The visit team heard that the higher trainees lacked paediatric training opportunities. The higher trainees in emergency medicine stated that they only saw paediatric cases if the department was exceedingly busy. They stated they saw approximately four to five paediatric trauma primary surveys. The higher trainees stated that there was no rotation into the paediatric section of the department and would not be able to meet the curriculum competencies. The emergency medicine consultants stated that they were aware as the trainees had raised these issues and the consultants were looking for a solution. One proposal was to try and synch the paediatric emergency medicine rota with the adult emergency medicine rota to allow trainees from either rota to swap over to gain more experience. There was also the idea raised to combine some teaching for paediatric and emergency medicine trainees. The higher trainees in emergency medicine felt that time spent triaging in the rapid access treatment (RAT) area was disproportionate to their curricula needs. They often missed handover and felt that space limitations in the emergency department restricted the effective use of this model of care. The higher trainees in emergency medicine would recommend the post for training but would like more paediatric and trauma exposure.	The Trust is required to clarify the policy for enabling higher emergency medicine trainees to lead trauma calls under the supervisor of the TTL and indicate how they will monitor this experience. The Trust is required to provide evidence of the exposure higher emergency medicine trainees have to paediatric patients as noted in the rota section above. The Trust is required to provide evidence of the proportion of time higher emergency medicine trainees spent in the RAT area compared to other areas of the department they are rostered too over a 3 month period (Resuscitation, majors, paediatrics, minors/UCC).	**Amber** Mandatory Requirement **Amber** Mandatory requirement

Good Practice	Contact	Brief for Sharing	Date
The anaesthetic LFG for ACCS trainees demonstrated good practice by appointing a liaison trainee who met with the trainees in a closed meeting before the LFG to feedback any concerns the trainees may have had regarding training. The liaison trainee, will then occasionally lead the LFG.	Dr R Brown	Please fill out the Quality and Regulation London and South East good practice case study form.	08/12/2015
The method for disseminating serious incident feedback to trainees and staff was excellent within the St. Mary's Hospital ICM department. It is recommended that this to be implemented across the Trust.	Dr R Brown	Please fill out the Quality and Regulation London and South East good practice case study form.	08/12/2015
The introduction of the ICM Basics Course to improve the trainees' preparedness to deal with ventilated patients, especially for those ACCS trainees who have yet to complete an anaesthetic attachment.	Dr R Brown	Please fill out the Quality and Regulation London and South East good practice case study form.	08/12/2015
The introduction of combined higher trainee emergency medicine and medicine teaching sessions, which has furthered understanding between the two specialties.	Dr R Brown	Please fill out the Quality and Regulation London and South East good practice case study form.	08/12/2015

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

Signed	
By the Lead Visitor on behalf of the Visiting Team:	*Dr Chris Lacy*
Date:	*8 December 2015*