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Quality and Regulation Unit (London and South East)

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

Quality Visit Report

17 November 2015

Final Report

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Visit Details	
Trust	Chelsea and Westminster Hospital NHS Foundation Trust – West Middlesex University Hospital
Date of visit	17 November 2015
Background to visit	Chelsea and Westminster Hospital NHS Foundation Trust acquired West Middlesex University Hospital in September 2015. This, in combination with the reconfiguration of services within North West London due to Shaping a Healthier Future meant that the emergency department had seen an increase in adult and paediatric cases. The visit therefore needed to assess the impact the acquisition and reconfigurations had had on the education and training within the Emergency Department at West Middlesex University Hospital, but also what opportunities this could offer. There had been intransigent issues of workforce and workload issues within the emergency department and the Care Quality Commission (CQC) highlighted these issues with a shortage of staff and more specifically a lack of emergency medicine consultants. The CQC also highlighted a lack of formal process within handover, a shortage of beds and the lack of clarity around patient pathways. The General Medical Council's National Training Survey results in 2015 indicated red outliers in 'clinical supervision', which corroborated with the known low levels of consultants and staff at the Trust. Trainees in General Practice (GP) had also reported problems with the levels of clinical supervision within the department. Foundation year two (F2) trainees in emergency medicine also reported red outliers in 'clinical supervision', 'supportive environment' and 'workload'. The last visit to the Trust in 2013 had also indicated low staffing levels, poor serious incident reporting, a high re-referral rate from the Urgent Care Centre (UCC) and a poor relationship with radiology. A previous specialty focused visit on 1 February 2011 reported issues relating to low registrar grade staffing levels, the inappropriate placement of core specialty training (ST) grade three trainees on the registrar rota and low consultant numbers that were well below recommendations of the Royal College of Emergency Medicine (RCEM) consultant numbers. The specialty focused visit was felt to be necessary to assess the training and education environment of the Emergency Department and to assess how well the posts allowed trainees to meet the curriculum competencies.
Visit summary and outcomes	The visit team met with the consultant body for the emergency medicine department that included the clinical director and college tutor, this was followed by a session with the higher trainees in emergency medicine, the core specialty training (ST) grade three trainee in paediatric emergency medicine (PEM) and GP trainees working within the emergency department and the urgent care centre (UCC). The visit team would like to thank the Trust's work for the high levels of attendance at both sessions. The visit team found a consultant body that although small was enthusiastic and valued education and training within the department. This was corroborated by the trainees who stated how supportive and friendly the environment was with the non-GP trainees stating how easy it was to get workplace-based assessments (WBPAs) signed off. The department had forged good relationships with other departments, especially paediatrics and to an extent the radiology department. The visit team urged the Trust to take of advantage of the cross department teaching and educational opportunities. The visit team heard that an excellent and competent group of nurses, whose work should be commended, staffed the department. The emergency medicine department also hosted very good and regular morbidity and mortality meetings. The visit team found a department that was contending with an ever-increasing patient caseload and yet was not having the reciprocal increase in staffing numbers. The visit team was concerned to find that all the rotas were understaffed and trainees were over-worked. This had two major implications for training and education: firstly, the trainee could not optimise the training opportunities resulting from a high and varied patient case mix. Secondly, the level of clinical supervision by consultants was extremely low. The visit team was concerned to hear that there was no formal consultant rota for the shop floor of the emergency department. The visit team urged the Trust to increase the number of consultants in the department either by cross-site working or through

	recruitment of substantive consultants to reach the minimum RCEM recommendation of 10 consultants thus providing 8am to 12 midnight clinical supervision seven days per week. The visit team would also like to see the educational responsibilities of consultants recognised in the consultants' job plans. Trainees also saw the workload as a positive aspect because the training opportunities were good although there was little direct clinical supervision; however, the PEM trainees' exposure to paediatric cases could be greatly enhanced. Areas that needed urgent attention included the very fragile middle grade rota, which the visit team felt should not rely on only four middle grades to cover the night shifts. The visit team felt that there needed to be a differentiation between the training grades to staff and patients and the role of the ST3 trainees must be clarified to the staff to ensure that it was understood that ST3 trainees were core trainees and not referred to as "registrars" as they were presently. The visit team suggested that consultants should have fixed Direct Clinical Care (DCC) shop floor sessions within the emergency medicine department and with the increase of paediatric cases from Shaping a Healthy Future there was a need for a sub-specialty trained paediatric emergency medicine consultant in the emergency department. There was one immediate mandatory requirement issued on the day because the GP trainees were not given any clinical supervision while on the 4pm to midnight shift in the UCC by the GP/consultants employed by the UCC. The visit team mandated that supervision should be provided on this shift or the trainees should be removed from this shift until suitable supervision was organised.

Visit team			
Lead Visitor	*Dr Chris Lacy, Head of London Specialty School of Emergency Medicine*	**Trainee Representative**	*Dr Georgina Blanco, Trainee Representative*
Trust Liaison Dean	*Dr Chandi Vellodi, Trust Liaison Dean, Health Education England North West London*	**Trainee Representative**	*Dr Matthew Mak, Trainee Representative*
Lead Provider Representative	*Dr Wendy Matthews, Training Programme Director, Imperial College Healthcare NHS Trust*	**General Practice Representative**	*Dr Ramesh Bhatt, General Practice Associate Director, Health Education England North West London*
External Representative	*Dr Roger Cordery, Training Programme Director, Barts Health NHS Trust*	**Lay Member**	*Jane Gregory, Lay Representative*
Visit Officer	*Lizzie Cannon, Quality and Visits Officer*		

Findings

Ref	Findings	Action and Evidence Required. Full details on Action Plan	Requirement
GMC Theme 1) Learning environment and culture			
EM1.1	**Patient safety** The visit team heard that the patients referred back from the Urgent Care Centre (UCC) were not	Supervision must be provided immediately or	Immediate

	always appropriate and numerous times the general practice (GP) trainees had asked for the clinical opinion of the higher trainee in the emergency department because the trainees in the UCC did not feel they could approach the GP locums staffing the UCC at night. The visit team heard that the department had a two-hour referral policy for the emergency department that was made possible due to excellent nursing staff who would triage, place cannulas, provide an echo cardiogram (ECG) and have the bloods back within 30 minutes of the patients arriving in the department. The trainees stated that there was never any pressure to rush patients through and sick patients would remain in the department until stable. The consultants did concede that although the patients were not rushed through, this may not be the patients' perception which the consultants did not think was positive for a patient. However, due to a heavy front-loaded system nurses would refer patients to the medical wards, especially the Acute Medical Unit (AMU) without first being seen by a doctor or the relevant specialty. The visit team also heard that when the department was at full capacity the consultants would appear on the shop floor, which the consultants confirmed. However, it was reported that only two out of the six consultants clinically saw patients and that when the department was busy, most consultants would go round and quickly refer patients to different specialties so that the two-hour Trust referral target was met. The visit team was concerned that because of the lack of consultants, combined with the very high patient caseload and the internal two-hour referral time, the focus was on service and meeting targets rather than on training and quality patient care. The trainees reported that one of the major problems of the emergency department was the lack of space to treat and ever-increasing number of patients. The trainees also stated that they would encourage the Trust to employ more middle grade doctors and consultants to create more staffing stability within the department.	until supervision is provided the GP trainees must be removed from the 4pm-midnight shift on the UCC. Please see action point in 1.3 below.	Mandatory Requirement
EM1.2	**Serious incidents and professional duty of candour** All the trainees stated that they felt free and encouraged to report serious incidents (SIs) and consultants gave formal feedback much later on. The trainees were unaware of any teaching that may be linked to the SIs. The trainees stated that there was a monthly morbidity and mortality (M&M) meeting and a local faculty group (LFG), which was attended by a consultant and senior nurse. The two meetings were conducted at the same time. The consultants stated that there was also a 'WhatsApp group' (a social media application) that was used to circulate the minutes of the LFG and to gather feedback before the LFG. The visit team was assured that no patient data was discussed through this mechanism, but the visit team required the Trust to review the use of the application to ensure that patient confidentiality was not being breached.	The Trust is to ensure that trainees using WhatsApp do not share any patient information. The Trust needs to clarify the appropriateness of using WhatsApp with the Caldecott guardian.	Mandatory Requirement
EM1.3	**Appropriate level of clinical supervision** The trainees stated that there was very limited consultant presence on the shop floor of the emergency department. On average the time consultants were on the shop floor was	The Trust is to establish a formal consultant rota	Mandatory

	approximated at five per cent and there was no set and defined shop floor consultant rota. The consultants were aware that there was limited time spent with the trainees on the shop floor but stated that they were still accessible to trainees from their offices if advice was required. The trainees stated that the consultants were in the offices that were separate from the department, but were available for advice and were accessible via phone. The trainees reported that one recent consultant appointee was more available to the shop floor which they commended. However, the visit team heard that consultants did not always attend bleep calls. The consultants said that the fact that there were only six of them and they had other commitments meant that there was not much time to attend the shop floor. During the weekends, the visit team heard that each consultant would cover the emergency department in different ways. The trainees stated that some consultants would attend the early ward round at 8am, while others would arrive later in the day but stay until 10pm instead of departing earlier at 6pm. The trainees stated that because there were such low consultant numbers the consultants were very stretched. The trainees stated that there was also no formal rota for the consultants in the evening, which meant that trainees were unaware of which consultant to call if trainees needed to escalate issues relating to patient care. The visit team heard that there was always a higher-grade doctor leading the department, who was not always an ST4 or above. The trainees stated that although the department was struggling for staff there was always supervision for the junior doctors. The consultants, although not always present were supportive regarding referrals to specialty teams. The visit team heard that if trainees needed clarification or support when making clinical decisions the trainees referred to medical specialty trainees if they were in the emergency department. The visit team was concerned to hear that even though the number of paediatric cases into the emergency department was already increasing from the service reconfigurations in Shaping a Healthier Future, there was no designated paediatric emergency medicine consultant for the department. This meant that the ST3 core trainee in paediatric emergency medicine received limited clinical supervision from consultants in the paediatric department. The GP trainees in emergency medicine felt that they received good supervision from the higher trainee or equivalent Trust-grade doctor in the week and that at weekends, during the day there was always a consultant accessible. The visit team was concerned to hear that the clinical supervision in the Urgent Care Centre (UCC) for GP trainees was variable. During the 8am – 4pm shift, there was good supervision and training opportunities. However, the trainees stated that they 'dreaded' the 4pm – midnight shift. The trainees stated that this shift was normally staffed by locums who were not sufficiently trained to supervise trainees and offered no support to the GP trainees.	shop floor clinical rota to make job plan direct clinical care (DCC) explicit so that trainees are clear about who they should contact for direct shop floor clinical supervision and who to escalate patient care too. The Trust is required to improve clinical supervision in the PEM department. In addition the Trust is to provide a recruitment plan for a PEM consultant for the paediatric emergency department with an intention to be in post within 12 months. This action point raised as an IMR (see 1.1 above)	Requirement Mandatory Requirement
EM1.4	**Responsibilities for patient care appropriate for stage of education and training** The visit team was concerned to hear that the ST3 core emergency medicine trainees were	The Trust is to provide a communication plan to	Mandatory

	referred to by the nursing staff as higher trainees. The trainees also stated that there was no way of distinguishing the grades of doctors in the department. The trainees stated that this could be confusing for nurses. The visit team suggested that the Trust should clarify to all staff the status of the ST3 doctors as core trainees; furthermore, the core trainees' roles and responsibilities should be disseminated to all staff. It is noted that this issue has been noted in the previous specialty visit in February 2011.	inform all emergency departmental staff as to the competency level of core ST3 emergency medicine trainees.	Requirement
EM1.5	**Rotas** The emergency department was very understaffed in all staff grades. The visit team heard that of the medical staff that were working, many had limited competencies which did not allow them to ease the workload of the department in the most effective way. The consultants were aware of the fragility of the rota especially that of the middle grade rota but stated that there had been many difficulties trying to recruit and retain staff. The lead visitor noted that this had been identified as an action point in the 2011 Trust specialty visit report. The visit team was concerned to hear that only four doctors were qualified to work on the night shifts in the emergency medicine department and there were only a few members of medical staff who could lead the department. The middle grade rota had recently deteriorated as one middle grade had left the Trust. This had resulted in the higher trainee working three out of four weekends. The visit team also heard that because there were very few staff for the night shifts the higher trainee was being encouraged to also do locum shifts to cover the gaps in the rota; this meant trainees were completing three rostered night shifts and two additional locum night shifts, The visit team heard that the ST3 trainees were not allowed to work night shifts. The latest shift they could work was 2am so they worked every other weekend. This meant that the trainees had four days off a month. The high workload and lack of staff meant that the trainees were working beyond the hours of the european working time directive (EWTD) and this was exacerbated by also working locum shifts. The trainees stated that there was a risk of burnout amongst the Trust-grade doctors because they were working seven nights in a row. The trainees stated that they only did three night shifts in a row over the weekend. All the trainees reported difficulties in attaining annual leave. They had to organise swaps when the rota was released, (which was normally late). Trainees were further constricted by the fact that leave could not been taken on night shifts. The higher trainees pointed out that they found this even more difficult as they were doing 3 out of 4 weekends on the current rota. The GP trainees stated that the rota was shared with the foundation year two doctors, which was a rolling four-week rota, organised by a separate consultant for six months. This allowed for working a weekend every fourth week. Normally GP trainees were allocated random blocks of two days leave. It was reported that the only method to get one whole week of annual leave was after finishing nights and then swapping one more day. The trainees stated that it was not possible for a trainee to be given two weeks of annual leave in a row.	The Trust is required to outline how the middle grade rota on the West Middlesex site can be enabled to provide a sustainable competent workforce that will meet the needs of the predicated future sector changes with implementation of Shaping a Healthier Future. The Trust is required to confirm that the current middle grade and ST3 grade rota is compliant with EWTD requirements. The Trust is to provide a summary of all the shifts worked by higher grade trainees over the last 3 months (1st September - 30th November 2015) including locum shifts. Please include the actual shifts worked, shift duration and whether the trainee was the most senior doctor in the department. The Trust is required to ensure that all rotas are produced in a timely way so as to allow trainees to take annual and study leave without swapping shifts.	Mandatory Requirement Mandatory Requirement Mandatory Requirement

EM1.6	**Induction** The higher trainees stated that they received a short local induction, but that this had been a pointless exercise in some cases as Human Resources had lost the details of some trainees. The emergency medicine induction was not formal and involved 30 trainees being led round the department by another trainee. The trainees stated that they would appreciate a through induction, which included the patient referral processes, how the machines worked and the out of hours system.	The Trust is required to improve the induction arrangements so that trainees are given an appropriate induction for their grade including explanation of departmental clinical protocols and processes, instruction on the use of key equipment and the Trust out of hours system	Mandatory Requirement
EM1.7	**Handover** The trainees reported that there was no formal handover for the night shift and the consultants' handovers in the morning varied on the consultant. The trainees stated that some consultant would go from bed to bed, while others would just do a "board based round". The trainees stated that during the night handovers happened informally between the incoming and departing doctors.	The Trust is required to ensure there is a formal, consistent handover process at the morning and night handovers.	Mandatory Requirement
EM1.8	**Protected time for learning and organised educational sessions** The GP trainees stated that the GP teaching was adequate and happened every Thursday from 2pm – 5pm. However, the shifts for the emergency department started at 4pm and so the trainees are not always able to attend the full three hours of teaching. However, the GP trainees stated that the higher-grade trainee or Trust-grade equivalent would be supportive and if the department was not too busy, the GP trainees could sometimes stay at the teaching. The visit team recommended that the teaching be moved to 1pm – 4pm to avoid this clash. The higher trainees in emergency medicine stated that regular teaching was held every Thursday, which was focused on clinical realities such as sepsis; however, the higher trainees commented that they would like focused and formal teaching on the curriculum too. The trainees in paediatric emergency medicine (PEM) stated that there was no dedicated paediatric teaching that trainees could attend but there was PEM regional teaching that could be attended. The consultants stated that there was a good interface between the paediatric and emergency medicine consultants. The visit team would urge the departments to use this to increase the amount of cross specialty teaching that occurs. The consultants reported that there was simulation training that occurred in situ on Fridays within the paediatric department, but none of the trainees reported that they had attended or were aware of this. The visit team heard that there were opportunities to undertake Quality Improvement Projects (QIPs) when time allowed.	The Trust is required to review the timing of the GP trainee teaching sessions to enable trainees to attend the teaching sessions. The Trust is required to provide a teaching programme for the coming 6 months demonstrating that it is linked to the 2015 RCEM higher curriculum and focused on appropriate curriculum elements. The Trust is required to provide a PEM teaching programme for the ST3 core trainees addressing the RCEM 2015 curriculum requirements, separate from the higher trainee requirements.	Mandatory Requirement Mandatory Requirement
EM1.9	**Adequate time and resources to complete assessments required by the curriculum** The trainees in emergency medicine stated that the consultants were accessible for signing off and completing the necessary assignments. The higher trainees stated that there were opportunities for sign off on ultra sound competencies.	The emergency medicine faculty group to work with GP trainees in emergency medicine to audit	

	The GP trainees stated that it was very difficult to get tickets signed off and it was not possible during the day to get workplace-based assessments signed off. The trainees identified that this was because the consultant did not recognise the GP e-Portfolio ticket as a legitimate message in the emails and thus trainees continually had to send repeated emails to ensure sign off.	the percentage of GP e-portfolio ticket requests are responded on the first occasion and to then implement the necessary changes to improve this rate of response timeliness.	Mandatory Requirement
GMC Theme 2) Educational governance and leadership			
EM2.1	**Effective, transparent and clearly understood educational governance systems and processes** The visit team heard from the clinical director that the emergency department sat within the medical division. The new medical governance structure that was being implemented as part of the integration of the two sites was stated to produce a robust clinical and medical management structure. This would give site specific lead for each site which would also be responsible for the training and education available on the site.		
EM2.2	**Impact of service design on learners** The visit team heard that the emergency department at West Middlesex University hospital attended to over 144,000 patients per year and 36,000 of those cases were paediatric patients. The emergency medicine department was staffed by six whole time equivalent (WTE) substantive consultant. This was well below the Royal College of Emergency Medicine's recommended number of at least ten WTE substantive consultants and with the large patient case, it would be best if the department employed at least 16 WTE consultants. The visit team heard from the clinical director that since the CQC visit in 2013 there had been a commitment by the Board to fund and recruit to 10 WTE substantive consultant posts over a three-year period. This it was stated would provide the department with a 16 hour a day consultant led service seven days per week. It is however noted that this same action point was generated in the 2011 specialty visit without significant progress in the resulting four years. The consultants in the emergency department stated that there was an inequity between the number of consultants at the Chelsea and Westminster hospital site and the number on the West Middlesex University Hospital site compared to the number of cases each department experienced. The senior management team in the morning sessions stated that the acquisition had given the opportunity of cross-site working. The visit team would support the addition of cross-site working for the consultants to replenish the number of consultants on the West Middlesex University Hospital site, while consultants are recruited. The consultants stated that the number of paediatric cases was already increasing and there were concerns that unlike the transition of maternity care the paediatric plan for managing the influx of patients had not been well planned. The consultants stated that there was no dedicated paediatric emergency medicine consultant in the department, which the trainees confirmed. The visit team heard that there was the opportunity for a paediatric emergency medicine consultant to work	The Trust to provide the staffing plans for the consultant expansion to the RCEM minimum, the timeline for expansion and the a statement outlining the Trust Boards commitment to funding this expansion to allow trainees placed in the emergency department to be appropriately supervised. It is recommended that this expansion should be over the next 12 - 18 months. (See action point 1.3 above).	Recommendation

	cross-site from Chelsea ad Westminster Hospital. The visit team supported this endeavour, as this would provide clinical supervision for PEM trainees, which was lacking. The visit team felt that the stark reality of the emergency department at West Middlesex University Hospital was that the workload would increase with more paediatric and adult cases as the reconfiguration of services in the North West of London moved forward. At the time of the visit, the number of consultants within the department was inadequate and this was reflected in the poor levels of clinical supervision by consultants and the high workload, which had caused trainees to not optimise the training opportunities, which were evident at the Trust. The visit team suggested that the Trust should employ more consultants within the emergency department in the interests of patient safety and education and training. The visit team heard from the consultants that there was a need for the rebuilding of the emergency medicine department because there was not enough space to treat the volume of patients that the department was treating. The trainees corroborated that the department needed rebuilding but both groups realised that this would be a lot of money and would be difficult due to the small and constrained footprint of the department. The visit team heard that the paediatric assessment unit had been opened to contend with the increased number of paediatric cases and the UCC also saw paediatric cases, however the trainees stated that the two units could reach capacity very quickly and was not enough to help permanently ease the workload and patient pathway in the emergency department.		
EM2.3	**Organisation to ensure access to a named educational supervisor** All the trainees confirmed that they had met and discussed the learning outcomes of the post with their educational supervisor.		
GMC Theme 3) Supporting learners			
EM3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees all stated that the emergency medicine department was a very supportive and friendly environment to work within and the trainees had not witnessed any bullying or undermining behaviour in the department. The GP trainees stated that the only behaviour that was found to be unsupportive was that of the GP consultants in the UCC between 4pm – midnight. The higher trainees stated that the more junior colleagues could receive unsupportive and unprofessional treatment from some medical departments, however generally the emergency department enjoyed good working relationships with the other departments. The trainees also stated that when junior did experience this type of behaviour then the consultants were supportive of the trainee and addressed the behaviour of the relevant department/ person The trainees stated that the process for requesting scans from radiology was very strange and concluded that the negative behaviour they experienced from the radiology department was due to	This action point raised as an IMR (see 1.1 above) The Trust is required to develop joint protocols for CT scanning so that trainees are clear about	Mandatory Requirement

	the protocols that the radiographers worked with. These protocols, it was reported, were not known by the rest of the emergency department and constricted decisions on scans. However, the visit team was pleased to hear that through the radiology consultant certain protocols had been relaxed or changed to ensure that scans could be accessed out of hours. All trainees were aware of the whistle blowing policy on the intranet.	the radiological requirements and processes for all clinical pathways.	
EM3.2	**Access to study leave** The visit team heard that despite the difficulties with annual leave, all trainees were able to receive study leave for courses and exams.		
GMC Theme 4) Supporting educators			
EM4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team was concerned to hear that the consultants had not had job plans signed off for several years and that the college tutor and clinical lead roles were not supported in the job plans. The consultants stated that there were eight to 10 special programmed activities (SPAs) within the job plans that were to include education and training responsibilities. The consultants stated that there was never enough time in the job plans and that they would appreciate if separate education programmed activities could be allocated for consultants. The consultants do not feel supported by the Trust. It is noted by in the Emergency Medicine annual School report that the West Middlesex emergency medicine consultant body had not provided the required preparation of support to the functions of the School of Emergency Medicine i.e. ARCPS, national and London recruitment, and to the ST3 to ST4 matching assessment interviews.	The Trust is required to provide evidence that all emergency medicine consultants have job plans and that these job plans reflect all clinical roles, the role of college tutor, and the roles of clinical and educational supervisors. The Trust to provide evidence that the emergency medicine consultant group are provided with appropriate support to provide educational support to trainees allocated to then, and enabled to attend to the required Lead Provider committees and faculty development sessions provided both locally and regionally.	Mandatory Requirement Mandatory Requirement
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** The ST3 PEM trainees were placed on the adult rota, which meant that the trainees could go for seven to ten days without seeing any paediatric cases. The opening of the Paediatric Assessment Unit (PAU) had exacerbated the lack of paediatric cases in the emergency medicine department. It had also resulted in the move of the higher trainee or equivalent trust-grade doctor from paediatrics, (who had been regularly in the emergency department), out into the PAU. This had limited the paediatric exposure for the ST3 PEM trainee and there had been a concerted effort to ensure that the trainee could attend the PAU, but this was only possible on the rare occasions when the emergency department was not busy and there were no adult cases to be seen. The consultants recognised that since the opening of the PAU, there had been an acute change for PEM trainees and there were allocated shifts in paediatrics. The visit team found that there were	The Trust to provide a separate Paediatric rota for the ST3 trainees doing PEM for the RCEM required 6 months. The Trust to agree a strategy to allow all trainees to complete the PEM requirement appropriate to their grade and clinical pathways.	Mandatory Requirement

	differing perspectives between the consultants and the trainees on how PEM trainees could gain more paediatric exposure. The visit team heard that the trainees undertaking PEM at the Trust would potentially achieve all the curriculum competencies but felt that it was difficult to build up the confidence to treat paediatric cases when only seeing a limited number, in an inconsistent manner. The area, which was particularly highlighted as a concern for PEM trainees, was the ability to be exposed to adequate numbers of paediatric trauma calls. The higher trainees in emergency medicine corroborated the difficulties experienced by the PEM trainees, stating that it would be difficult to maintain the paediatric skills. The higher trainees in emergency did report that there was exposure to minors because while on the night shift there were enough cases. However, the GP trainees stated that they did not receive exposure in minors and were unsure whether the curricula competencies could be achieved. The trainees stated that there was no exposure to x-rays and interpretation, which they would appreciate. The majority of trainees would recommend the post for training despite the very high workload because of the large patient case mix. The higher trainees in emergency medicine appreciated the opportunity to act up lead and manage a department which they found invaluable. However, the higher emergency medicine trainees stated that the post was unsuitable for a higher trainee who was not as confident or competent because it involved making many important clinical decisions without direct shop floor consultant supervision.			

Good Practice	**Contact**	**Brief for Sharing**	**Date**
All trainees reported how supportive the consultant body was. The Department was to be commended for the morbidity and mortality monthly feedback which the trainees valued. The trainees commended the strong nursing team within the emergency department and the good relationships with most other specialties.			

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

By the Lead Visitor on behalf of the Visiting Team:	*Dr Chris Lacy, Head of London Specialty School of Emergency Medicine*
Date:	*21 December 2015*