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Pan-London Quality and Regulation Unit

Barking, Havering and Redbridge University Hospitals NHS Trust Emergency Medicine and ACCS Specialty Focused Visit

Quality Visit Report

19 November 2015

Final Report

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Visit Details	
Trust	Barking, Havering and Redbridge University Hospital NHS Trust
Date of visit	19 November 2015
Background to visit	The London School of Emergency Medicine requested to visit emergency medicine and acute care common stem (ACCS) alongside the Trust-wide Review due to the adverse General Medical Council National Training Survey (GMC NTS) results in 2014 and 2015 and the potential use of a non-recognised training site for emergency medicine higher trainees. An informal visit took place to King George Hospital in August 2011 to review if the site was suitable for higher specialty training. However, the site was never commissioned as a training site for emergency medicine. The GMC NTS results in 2015 generated one red outlier in ACCS for access to educational resources and six pink outliers. Emergency medicine generated nine red outliers in the 2015 survey; most concerning were those in overall satisfaction, clinical supervision, and clinical supervision out of hours, induction, adequate experience and supportive environment.
Visit summary and outcomes	The visit team met with the college tutor for emergency medicine (responsible for both sites), and the clinical and educational leads for emergency medicine and acute care common stem (ACCS). The visit team met with the divisional director for acute medicine separately. The visit team met with eight core trainees in: ACCS specialties, the defined route of entry into emergency medicine (DRE-EM) programme, general practice trainees (GP), and two higher specialty training year four (ST4) trainees in emergency medicine. Finally, the visit team met with two emergency medicine educational supervisors, two paediatric resuscitation cases were in the emergency department, which prohibited attendance of more trainers. **Acute care common stem (ACCS)** The ACCS trainees recommended the training in intensive care and anaesthetics. The ACCS trainees commended the consultant supervision they received from intensive care and paediatric emergency medicine consultants. Only one third of trainees recommended the emergency department for friends and family, however they felt that they would be happy to bring a sick child to Queen's Hospital or for their friends and family to be admitted to intensive therapy unit (ITU). Trainees reported being unaware of an ACCS/DRE-EM local faculty group, and the visit team recommended the establishment of such a group. The ACCS trainees' rota allowed two non-airway skilled trainees to be on the ITU and high dependency unit (HDU) overnight. **Emergency Medicine (EM)** The visit team was pleased to hear of the Trust's increased support for the EM consultants and heightened awareness of emergency pathways. The visit team heard that the emergency medicine trainees appreciated the breadth of cases and patients admitted to the emergency department, and the training opportunities available to them, although it was felt to be too busy to appreciate this. Emergency medicine trainees were currently working cross-site even though the King George Hospital had not been commissioned as an emergency medicine training site. The visit team recommended that emergency medicine trainees be consolidated onto the Queen's Hospital site, to maximise educational support. It was felt that this would improve morale for higher trainees who felt undervalued as career emergency medicine trainees and cut off from supporting each other as they were often on different sites. The trainees felt stretched on night duty and it was common for trainees to finish a shift feeling that they had compromised patient safety during their shift. The additional support at Queen's Hospital would allow supplementation of the tier one rota to allow a second tier one middle grade overnight. The panel was concerned to hear that there was no non-invasive ventilator (NIV) equipment available in the emergency department, which created a risk

	to patient safety and potential harm. The Trust was issued with an immediate mandatory requirement to ensure that there was immediate access to NIV equipment in the emergency department and expertise to be available to immediately start NIV therapy. The visit team recommended that emergency medicine consultant numbers needed to be increased. The visit team noted the importance of attracting current trainees to consultant posts. From a trainee's perspective the consultants were not as up to date with the new Royal College of Emergency Medicine curriculum. The visit team recommended that the Trust worked with the Lead Provider to develop a faculty education programme.

Visit team			
Specialty Lead Visitor	Dr Chris Lacy, Deputy Head of London Specialty School of Emergency Medicine	**Trust Liaison Dean**	Dr Indranil Chakravorty, Trust Liaison Dean
Lead Provider Representative	Dr Helen Cugnoni, Lead Provider Representative for Emergency Medicine	**External Representative**	Dr Oliver Spencer, Emergency Medicine External Clinician
External Representative	Dr Helena Scott, Anaesthetics External Clinician	**External Representative**	Dr Vivek Sristavava, Acute Medicine External Clinician
GP Representative	Dr Naheed Khan-Lodhi, Associate Director GP School	**Trainee Representative**	Dr Katy Jones, Emergency Medicine Trainee Representative
Lay Member	Robert Hawker, Lay Representative	**Visit Officer**	Michelle Turner, Quality and Primary Care Manager

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 emergency medicine (EM) trainees stated that there was no non-invasive ventilator (NIV) equipment in the emergency department (ED). If they needed to place patients on NIV then trainees were required to try to find a spare machine available on a ward. This led to delays in patients commencing NIV treatment. The clinical and educational leads reported that the department and Trust were aware that the number of whole time equivalent (WTE) consultants was not appropriate to the high number of attendees to the ED. The visit team heard that there were currently 11.2 WTE consultants in emergency medicine across the two sites. A number of measures had been put in place to mitigate the risk from this low number; four new consultant appointments and a possible fifth were	The panel was concerned to hear that there was no non-invasive ventilator (NIV) equipment available in the emergency department creating a risk to patient safety and potential harm. Access to NIV equipment and expertise should be available immediately in the emergency department. The visit team recommends that the Trust	Immediate Mandatory Requirement

	confirmed for January to March 2016. The visit team was informed that appointed candidates had been consultants for many years and had much experience, although none had gained certificate of completion of training (CCT) through a UK training programme. The clinical and educational leads stated that the urgent care centre (UCC) was led by the general practice (GP) team and emergency nurse practitioners. The visit team heard that approximately 25% of patients at Queen's Hospital were referred to the UCC. At King George Hospital, patients were streamed through the UCC and so had a higher percentage of admittance in the UCC. The clinical and educational leads commented that the philosophy of the rapid assessment and treatment (RAT) system was to mitigate and manage high risk patients, to ensure the acutely unwell patients were immediately seen by a senior doctor for rapid treatment. The clinical and educational leads indicated that they could not confirm that 100% of patients had had treatment started prior to being referred to a ward. The visit team was concerned with reports that patients were sent to the admitting wards under a 'plus one' policy when the emergency department was at full capacity. The clinical and educational leads reported that the 'plus one' was not routine policy and it was only implemented when full capacity was reached, as a surge management protocol. The visit team heard that if patients could not be moved to a ward, their care would be continued in the ED. The clinical and educational leads reported that there had been a change in the Trust 12-18 months prior to the visit. Capacity had been an on-going issue within the Trust, and in the past it was common for the whole system to close up with no capacity to move patients. There were on-going difficulties with referring patients to community settings. Every morning the nurses on the ward had to identify patients to be discharged, which influenced the numbers of patients qualifying for the 'plus one' protocol. The higher emergency medicine (EM) trainees stated that they were the most senior doctor in the department overnight. They stated that it would help to have a second middle grade colleague working alongside them, to share the workload and responsibility. It would be beneficial in terms of core trainees escalating concerns and in general monitoring of the ED out of hours. The visit team heard that following a night shift, the trainees would often go home, reflect on the shift and felt that it was unsafe on many occasions. The trainees were the main decision-maker at night, and the pressure was often too much for the trainees' stage of training and experience. The EM trainees stated that they took breaks whenever it was possible; the shift started at 8.30pm, but trainees often did not take the first break until 6am. They indicated it was difficult, as the shifts were arduous so they needed to pace themselves so that their energy did not dissipate. The higher trainees always encouraged the core trainees to take breaks regularly. The shift pattern and heavy workload often left the trainee feeling drained. The educational supervisors commented that they were not aware of there being issues with imaging out of hours. The Trust used the Australian system from 10pm for imaging, the consultants were not aware of any problems with this.	review plans for emergency medicine consultant recruitment to increase consultant numbers to the minimum Royal College of Emergency Medicine of ten consultants per site. In addition the Trust needs to consider how it can attract recently qualified CCT holders to the Trust. The appointment of recent CCT holders would allow that Trust's consultant body to broaden its knowledge of the Royal College of Emergency Medicine curriculum and assessment system to the benefit of trainees in emergency medicine.	Recommendation

	The visit team noted that the King George Hospital site was not recognised by the Royal College of Emergency Medicine and GMC for training in emergency medicine nor had it been commissioned for training by the London School of Emergency Medicine. The visit team recommended that emergency medicine trainees should not be placed at the King George Hospital site from February 2016. Trainees would benefit from being consolidated onto one site, to maximise educational support; the visit team felt that this would improve morale for the higher EM trainees who felt undervalued as career emergency medicine trainees. Trainees reported feeling stretched on night duty and were often left feeling that they had compromised patient safety at the end of their shift. The withdrawal of higher EM trainees from King George Hospital site would allow supplementation of the tier one rota on the Queen's Hospital site to allow a second tier one middle grade overnight.	The Trust is required to consolidate all emergency medicine trainees onto the Queen's Hospital site.	Mandatory Requirement
EM1.2	**Serious incidents and professional duty of candour** The EM trainees confirmed that that the Trust encouraged concerns to be raised and clinical incidents to be reported. The EM trainees stated that following two paediatric deaths in the ED over night, they had attended a department debrief with the educational supervisors which they found useful.		
EM1.3	**Appropriate level of clinical supervision** The senior management team stated that there had been an effort to increase recruitment to the emergency department consultants. Three consultants had been appointed from other organisations, with one consultant coming from a strong academic background; the department was keen to unlock this potential to manage volume of patients attending the ED. The clinical and educational leads confirmed that the Trust had 8.2 whole time equivalent (WTE) substantive consultants, and three WTE long term locums appointment, which totalled 11.2 WTE consultants. Two of these consultants had a sub-specialty interest in paediatric emergency medicine (one from a paediatric background and one from an emergency medicine background), who covered the paediatric emergency department. The visit team was informed that none of the five recently appointed candidates had gained a CCT in emergency medicine in the UK. Of the current consultants none had gained their CCT in the last five years. The clinical director reported that new patient attendances were currently 145,000 per annum for Queen's Hospital and 110,000 for King George Hospital. The visit team heard that all consultants and specialty trainees worked across both sites. The trainees provided clinical cover at King George Hospital on a regular rostered basis and were not placed there for specific management or leadership training sessions. The clinical director stated that the on call night rota covered both sites. There were consultants on both sites until 10pm and the visit team was informed that the consultant at Queen's Hospital regularly stayed until midnight, and on occasions were on site until 1-2am. The visit team heard that there were no consultants that were based solely on one site, but some consultants may be		

	identified as working predominantly on one site, i.e. the clinical lead at King George Hospital. The clinical and educational leads confirmed that they ensured there was appropriate supervision for the ACCS trainees in intensive care medicine at the start of the rotation. There were eight specialty doctors working at King George Hospital, but the ACCS trainees stayed at Queen's Hospital. There was intensive care consultant presence every day from 8am until 6pm, and one consultant was available until 9pm. After this time, the consultants were available from home by telephone or the outreach service. The clinical and educational leads confirmed that the higher specialty trainees covered the neurological intensive care unit, and the ACCS trainees could speak to these trainees for help out of hours. The visit team heard that the year one core training (CT1) anaesthetic trainees never worked on the ITU. There was an anaesthetic higher trainee on the on call rota covering both sites. The acute medicine ACCS trainee worked on the high dependency unit, was on call, and directly supervised by the intensive care senior trainee. The ACCS trainees in intensive care stated that they had good clinical supervision, and had access to support when required, however at night there was no higher trainee or consultant to provide supervision for procedures. The GP trainees in emergency medicine commended the support given by the two paediatric emergency medicine consultants through the day but noted that it was difficult to get support in the evening and overnight. The EM trainees reported that the clinical supervision was variable, due to the workload restraints of the department and the numbers of staff. They stated that they had a consultant present with them for approximately 35% of the time. They confirmed that they were aware of who to contact for advice at all times. The higher EM trainees reported that consultants would come in out of hours if called but would often work with the minimum of communication and then leave. Trainees reported that the consultants at King George Hospital were mostly locums.	The Trust is required to ensure that there is appropriate supervision of ACCS trainees undertaking procedures at night in the ITU.	Mandatory Requirement
EM1.4	**Responsibilities for patient care appropriate for stage of education and training** The clinical and educational leads confirmed that they were still getting to grips with the defined route of entry into emergency medicine (DRE-EM) trainees and the training requirements. They had been treating them the same as ACCS trainees. The new DRE-EM trainees were treated like novice anaesthetics trainees when starting anaesthetics. Those DRE-EM trainees starting in the intensive care unit may not have completed the airways competencies but the majority of the time an anaesthetics senior trainee was available. The EM higher trainees reported that the ED middle grade rota was split into a tier one and tier two rota. A DRE-EM trainee had been placed by the Trust on the tier one rota, which was for higher-grade doctors (ST4 or above). The Trust and department did not appear to understand the training pathway of the DRE-EM trainee. They understood the trainee was a senior level while the EM higher trainees were aware that the trainee was only at core level. The EM higher trainees	The Trust is to ensure that all the educational supervisors understand the role of the DRE-EM trainee. The College Tutor for emergency medicine to ensure that all DRE-EM trainees have a senior experienced emergency medicine educational supervisor to provide overall guidance to each DRE-EM trainee while they are attached to the Trust. This educational supervisor can be in addition to the educational supervisor assigned by the specialty they are attached to (e.g. Anaesthetics or Intensive Care). This will provide additional career support to a group of trainees that have come into DRE-	Mandatory Requirement

	raised this with the leads in the ED, and said that the DRE-EM trainees should not be placed on the rota in the department at night unsupported. The trainee attended one night shift, before this was changed on the rota The ACCS trainees reported that some of the trainees started in the intensive care unit due to the high number of novice anaesthetists in the Trust. The trainees reported that this had created a gap in having an airways skill competent person always present. The ACCS trainees stated that although they were not all airway competent, there was always a middle grade or higher specialty trainee within the vicinity that had airways skills. The core anaesthetics trainees had completed the IAC at the time of the visit, so support was greater. When all the ACCS and DRE-EM trainees started anaesthetics in August 2015, there was a period of three months, when there was more core trainees on duty and only a Trust grade doctor covering the night rota, which had potential for patient safety concerns. The higher EM trainees reported that the service pressures placed on the trainees on the tier one rota, particularly at night made the Queen's Hospital site a tough department to be assigned to, particularly if this was the first placement as a higher trainee (ST4 level). The trainees reported the nights felt unsafe because of the volume of patients attending and the lack of other senior decision-makers. They commented that they would welcome another senior decision-maker working alongside them. The physical layout of the department meant that it was often difficult for the higher EM trainees to keep an eye on all areas and support junior colleagues as the ED was spread out over a large area and difficult to get around.	EM from a variety of backgrounds. These educational supervisors are encouraged to work closely with the NCEL DRE-EM lead Dr Helen Parker and the DRE-EM TPD Dr Chris Lacy. The Trust to ensure that the all staff in the ED are aware that core EM trainees (ACCS and DRE-EM trainees) are core trainees and not higher or registrar grade trainees. The Trust to ensure that there is no confusion over who can be called a "registrar" as this implies they are a higher trainee and can work unsupervised. The Trust is required to review the supervision of core ACCS trainees in anaesthetics and critical care to ensure that there is appropriate airway competent supervision provided at all times, particularly on the night shift. The Trust is required to review the higher trainee grade (Tier1) rota to ensure patient safety and adequate supervision of core and foundation trainees is maintained at night. The visit team recommend there should be a second Tier 1 doctor on the duty on the Queens site on the night shift (see 1.5 below).	Mandatory Requirement Mandatory Requirement Mandatory Requirement
EM1.5	**Rotas** The clinical and educational leads stated that all trainees and trainers covered both sites. There were eight F2 trainees, four ACCS trainees (one a specialty trainee in acute medicine and three in anaesthetics), one DRE-EM trainee, and three ST4-6 trainees. The clinical and educational leads reported that the majority of the service delivery was performed by Trust grade doctors, clinical fellows, and long-term locum staff. The clinical and educational leads clarified the structure of the ACCS programme. In anaesthetics there were 48 consultants across both sites, 44 trainees of which over half were novice trainees. The visit team and educational leads recognised that the number of novice anaesthetic placements this year to the Trust had been exceptionally high and placed difficulties on providing supervision. The emergency medicine clinical and educational leads confirmed that the previous group of EM higher trainees were offered the choice of shift length and rota structure. The higher trainees	The visit team recommend that the Trust review the distribution of novice anaesthetic trainees with the Academy of Anaesthesia and School of Emergency Medicine to ensure there is an appropriate ratio of novice anaesthetists to	Mandatory Requirement

	chose to work longer hours (12 hour shifts) with longer breaks. The higher trainees worked one in four weekends. The department had dedicated shifts and roles: the leading higher trainee on the "tier one" rota was responsible for 'majors' and was in charge of the shift overall. The other trainees would be allocated to areas in the department i.e. resuscitation, paediatrics, light majors etc. The ACCS trainees in intensive care reported that the rota was well balanced; they worked one weekend in four and covered the acute on call. The ACCS trainees confirmed that there were ten beds in the neurology intensive care unit, 22 patients in the general high dependency unit. There were three anaesthetic airway competent trainees covering each of these areas. The ACCS trainees stated that the intensive care rota structure meant that on some occasions there could be two core trainees without airways skills on the HDU and ICU. The neurology ITU was staffed differently on a specific rota. The ACCS trainees reported that overnight there was always a non-training staff grade doctor available with airway skills to support the emergency department but they may be in theatre for emergency operations. During the day the trainees reported that airway support may be provided initially by a core grade equivalent. The EM higher trainees confirmed that they worked across both sites, and they had 12.5 hour shifts. They spent a significant proportion of the night being the most senior doctor in the ED. The trainees worked four nights on, with three days off, and although the shifts were intense they had time to recuperate following a night shift. The shifts were intense at Queen's Hospital due to the workload, but were equally intense at King George Hospital due to there being less staff on the shop floor. The EM higher trainees stated that they sometimes started the night shift with 124 patients waiting to be seen. They would spend the night managing the department, and the more junior doctors would escalate concerns when necessary. However, they often did not fully know what was happening in majors light area. It was hard to know what was going on in every area, when in charge of the department. The higher EM trainees explained that the middle grade rota had two tiers. The tier one rota was designated to trainees at level ST4-6 or equivalent non-training grade, and tier two was for all trainees less than ST4. The trainees indicated that there should be two doctors from each tier on each night shift, but there was insufficient staff to allow for two on the tier one rota at Queen's Hospital at night. The EM higher trainees reported that they had concerns about the quality of the locums recruited to fill the Tier 1 rota vacancies. Many were at Tier 2 level of FY2 level.	available supervisors. The Trust is required the outline the provision of anaesthetic support to the emergency department during the working week and out of hours periods. The Trust is required to review the higher trainee grade (Tier1) rota to ensure patient safety and adequate supervision of core and foundation trainees is maintained at night. The visit team recommend there should be a second Tier 1 doctor on the duty on the Queens site on the night shift.	Mandatory Requirement
EM1.6	**Induction** The clinical and educational leads reported that the Trust had a high proportion of novice anaesthetist trainees across ACCS, and core anaesthetics. The visit team heard that the August		

	2015 induction was manageable. All trainees were supernumerary for the first three months, and worked only daytime at King George Hospital and night time as supernumerary at Queen's Hospital. There was a fixed induction programme for every rotation into the intensive care unit to ensure that every group of trainees was fully inducted to the department. The ACCS trainees stated that there was a Trust and department induction. They were inducted into the intensive treatment unit and anaesthetics areas. The trainees were able to go to the novice anaesthetic course run by Barts Health NHS Trust. The ACCS trainees starting on nights on intensive care reported that they had no induction to the clinical protocols relevant to this area. The EM higher trainees stated that they all received a good Trust and departmental induction at Queen's Hospital. The induction covered most aspects of the role. The department induction was focused to Queen's Hospital, and there no formal induction for trainees rotating to King George Hospital. The visit team heard that the Trust emphasised the induction for educational purposes, and it was clear that the Trust was aiming to ensure the induction and trainee placements were educational which was not always apparent at other hospitals. The trainees praised the effort put into the Queen's Hospital induction.	The Trust is required to ensure all ACCS trainees starting in intensive care receive appropriate Trust and departmental induction prior to commencing their first shift.	Mandatory Requirement
EM1.7	**Handover** The ACCS trainees were not aware of a formal hospital at night handover for intensive care. They confirmed that consultants would stay longer on site, if there was a patient they were concerned about. The higher EM trainees reported that some consultants left the departments after their evening shift without meeting with them. Trainees would welcome a formal handover process in the late evening from the departing consultant.	The Trust is required to initiate a formal night handover procedure in intensive care. The Trust is required to initiate a formal night handover procedure in the emergency department prior to the consultant leaving the site.	Mandatory Requirement Mandatory Requirement
EM1.8	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The ACCS trainees stated that as there were a high number of anaesthetic trainees the core anaesthetic trainees covered many basic cases which the ACCS trainees missed out on and lost the educational opportunity. The ACCS trainees reported stated they had a good opportunity to learn on the shop floor in ITU on the 8am to 6pm shift and would recommend the post as they were encouraged to learn. The higher EM trainees stated that they received a good exposure to cases in the ED. They could easily meet the curriculum requirements at Queen's Hospital however, difficulties in meeting the curriculum requirements stemmed from the service pressures. There was no time for trainees to reflect on cases, and receive feedback.	The Trust is required to review the allocation of EM higher trainees to the paediatric area to ensure they trainees have adequate exposure to paediatric cases to achieve the required higher	Mandatory Requirement

	The visit team heard that the higher EM trainees had limited experience to paediatric cases and were not rostered to the paediatric area very often. The higher EM trainees reported they had adequate opportunities and supervision to complete the ultrasound competences. Exposure to minor injury and illness was limited due to the presence of a privately tended UCC. The higher EM trainees reported that consultants were visible on the shop floor and estimated that they were present for approximately 35% of a trainee's clinical shifts in the ED. However, the trainees emphasised that most of their learning was self-directed and only one consultant had sat down in person to do a workplace-based assessment with a trainee. From a trainee's perspective some consultants were not as up to date with the new RCEM curriculum.	EM paediatric competences. The Trust is required to ensure that trainees gain adequate exposure to minor injury and minor illness cases.	Mandatory Requirement
EM1.9	**Protected time for learning and organised educational sessions** The ACCS trainees stated that they were released for anaesthetics teaching. The trainees were released for ACCS regional training days. The trainees reported that the quality of the teaching was good. The EM higher trainees stated that there was good formal teaching every second Thursday for three hours, but no shop floor teaching. The GP trainees in ED reported receiving four hours teaching every second Thursday which included a case discussion, simulation and a guest speaker in addition to their GP training programme. The visit team heard that the visit's trainee session clashed with the teaching session for EM. The department cancelled the teaching which the trainees thought was unfair to not have teaching because of this meeting. The trainees raised this to management, who re-instated the teaching. The EM trainees stated that shop floor teaching was dependent on the consultant; some were more proactive than others. The trainees made an effort to teach the junior doctors where possible.		
EM1.10	**Adequate time and resources to complete assessments required by the curriculum** The EM higher trainees stated that they experienced considerable difficulties with completing workplace-based assessments (WPBAs). The workload was too heavy to allow for time for completion. The trainees, who had not used e-portfolio before, relied on their colleagues showing them the system. The EM trainees stated that they were confident that the educational supervisors understood the curriculum requirements of stages of training however not all clinical supervisors were as aware. However, they indicated that they were unsure if the educational supervisors were aware of the recent changes to the ST4-6 curriculum and the requirements for Annual Review of Competency Progression (ARCP) outlined in ARCP checklists. The EM higher trainees confirmed that they had their first extended supervised learning events (ESLEs) booked for the day following the visit. The educational supervisors had not approached	The visit team recommends that the EM	

	the trainees to complete this; instead the trainees had to push for it and book it in. The trainees were unsure if the educational supervisors understood the requirements for the new assessment criteria. The trainees commented that they regularly met their educational supervisors and had discussed their educational requirements and curriculum. The educational supervisors indicated that not all consultants were up to date with the new curriculum, or were fully au fait with the new e-portfolio assessments, ESLEs. They indicated it would be useful to have an external colleague attend for a teaching session. The educational supervisors stated that the department had not discussed or held any meetings to discuss the changes in the WPBAs. They were aware of the need to complete ESLEs and had organised meetings organised for this.	educational and clinical supervisors work with the NCEL Lead Provider to instigate faculty training for all EM consultants in: the requirements of the new 2015 curriculum, the new assessments, the ARCP checklist requirements and the College examination structure changes	Recommendation
GMC Theme 2) Educational governance and leadership			
EM2.1	**Effective, transparent and clearly understood educational governance systems and processes** The trainees reported that they were not aware of any local faculty group (LFG) for ACCS or DR-EM. They indicated that they would find an LFG or joint meeting helpful, to have time as a group together to discuss and share thoughts. The EM trainees stated that as they worked across the two sites and had different shift patterns, they rarely had the opportunity to meet their colleagues. There were no joint meetings in which they could share information or concerns.	The Trust is required to establish local faculty groups for ACCS (involving all four participating specialties) and Emergency Medicine with formal minutes and trainee representative attendance.	Mandatory Requirement
EM2.2	**Impact of service design on learners** The clinical and educational leads confirmed that the emergency medicine department sat within the acute medicine directorate. The clinical and educational leads confirmed that re-configurations for the emergency department at King George Hospital remained uncertain. The department had hoped that the downgrading of the ED to be closed from 10pm was implemented by the start of winter 2015, to help with the winter pressures. The visit team was informed that the Trust was discussing an implementation of a phased closure with the clinical commissioning group (CCGs) and East of England Ambulance Service NHS Trust. The clinical and educational leads stated that the ED would not close entirely at King George Hospital, but there would be enhanced primary care and UCC out of hours. The divisional director confirmed the future plans of Trust, the ED at King George Hospital would be downgraded out of hours. The hospital would have a phased reconfiguration, and become focused on care of the elderly. The North East London Foundation Trust was implementing community services on the site which would benefit geriatric medicine and pathways there. The divisional director reported that in terms of the ED, it was becoming increasingly clear that		

	there was a high risk factor to running two EDs at night. The aim would be for ambulances to stop taking patients to King George Hospital from 10pm, staffing cover could then be higher at Queen's Hospital. King George Hospital would operate a UCC out of hours. The visit team heard that this had been the planned reconfiguration for a long time; the CCG had put this on hold due to the Trust being placed in special measures.		
EM2.3	**Organisation to ensure time in trainers' job plans** The clinical and educational leads reported that the majority of the consultants in intensive care were anaesthetists; they all had joint job plans.		
EM2.4	**Organisation to ensure access to a named clinical supervisor** The educational supervisors stated for a department of a similar size, they required approximately 18 WTE consultants. This would make a big difference to the department. The consultants had been asked to work until midnight, and if the department was busy they would stay until 2am. There was no time off or remuneration; they were expected to be back in work the following day. The visit team heard that the staffing numbers and rota were tiring. The educational supervisors were aware of the need to improve the reputation of the department and improving the experience of the trainees was key to changing the future of the hospital and Trust. There were three long term locums in the department, these individuals were highly qualified members of the team but as they were not substantive they were unable to provide educational supervision which piled the pressure on the other consultants. The educational supervisors confirmed that the ED had two paediatricians with sub-specialty training in emergency medicine who covered the paediatric ED. The EM trainees stated that the consultant shifts finished at 10pm. The consultants regularly stayed later than this time depending on the workload of the department. The visit team heard that there had been occasions when the EM trainee was not aware that the consultant had left, most likely as they were reviewing a patient at the time the consultant finished. The EM trainee suggested that a quick informal discussion before the consultant left would seem the appropriate thing to do. It would feel that training was being reinforced. The trainees confirmed that all consultants were accessible over night by telephone, and would return to the department if the trainee requested. The ACCS trainees stated there was always consultant supervision in the resuscitation area between 10am and 6pm.	The Trust is to ensure that there is a formal handover between the departing evening consultant and the higher trainee or equivalent in charge for the night shift. See Ref 1.7 above.	Mandatory Requirement
GMC Theme 3) Supporting learners			
EM3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The clinical and educational leads stated that there were regular meetings between the ACCS specialty leads to discuss trainees. The visit team heard that the department had confirmed that		

	pastoral needs of ACCS trainees should be met by the specialty school they were in.		
EM3.2	**Behaviour that undermines professional confidence, performance or self-esteem** The trainees did not report any formal concerns with bullying or undermining. The core trainees in the emergency department reported that the middle grade doctors were approachable as were most of the consultants; however there was one consultant they found difficult to approach and they tended to avoid this person. The educational supervisors stated that they were unaware of any significant difficulties with other departments. There were issues with difficulties in referring and accepting of patients to medical teams.		
EM3.3	**Timely and accurate information about curriculum, assessment and clinical placements** The trainees commented that they often received the rota with three months' notice and no more. The trainees found there were limited opportunities and it could be difficult to swap shifts with colleagues.		
EM3.4	**Access to study leave** The ACCS trainees indicated that they struggled to take study leave. They were only able to take study leave when on day shifts, not when on the on call rota which limited time for study leave. There was limited support to swap shifts on the rota. The trainees commented that the Trust insisted on a minimum of six weeks' notice for study leave, but the trainees often did not have this much notice for educational activities. They would appreciate greater flexibility. The visit team heard of one example, when a trainee attended an examination followed by two nights on the on call rota. One ACCS trainee in intensive care had been refused study leave on two occasions despite giving more than six weeks' notice of intent. The EM higher trainees reported that they had been able to access study leave when required, they just required plenty of notice.	The Trust to clarify the study leave policy for mandatory training days and exams for ACCS trainees and consider how they can better accommodate the specialty study leave needs of all ACCS trainees. Better understanding of the ACCS trainees' needs could be facilitated through the establishment of an ACCS Faculty Group.	Mandatory Requirement
GMC Theme 4) Supporting educators			
EM4.1	**Access to appropriately funded professional development, training and an appraisal for educators** The educational supervisors stated that the ED had had two workshops to reflect on practices and implement changes, one ran by the Trust Development Agency (TDA). The department had been feeling disgruntled as a whole and there was a need to improve this. There was a perceived lack of support from management in the ED; this was linked to a lack of reality and support to the real challenges faced by the ED. The new management of the Trust were addressing concerns. They had interacted with the ED and were proactive in making changes and improvements. The		

	educational supervisors indicated that staff needed to feel valued, supported and encouraged in order for a complete change to take place in the ED. The experience was improving and getting better but they had a long way to go. The educational supervisors stated that the faculty development was poor for ED. At the time of the visit there was no system or structure in place for educational appraisals, but they indicated that they felt this would be introduced once the new DME was in post. They needed to ensure their educational portfolios were up to date. The college tutor had not been included in the lead provider mailing list for meetings, which had been rectified.	The Trust is required to ensure all consultants have an up to date educational appraisal. The Trust is to ensure all clinical and educational supervisors in the emergency department are aware of the requirements of the RCEM ACCS, DRE-EM & higher EM curriculum and assessments required for each.	Mandatory Requirement
EM4.2	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team learnt that the college tutor worked across both sites. The college tutor confirmed that time had been made available in their job plan to volunteer at the School of Emergency Medicine ARCP panels in January 2016. The educational supervisors stated that they felt supported by the department and Trust. The educational supervisors stated that clinical supervisors did not receive adequate time in the job plans for completion of workplace-based assessments. The educational supervisors stated that although individually the trainers were likely to have adequate time in job plans, the busyness of the department and the rota gaps prohibited time for educational activities to occur.	The Trust is required to ensure that clinical supervisors have appropriate time in their job plans the support the requirement to complete work place based assessments.	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 clinical and educational leads stated that there was consultant-led teaching at Queen's Hospital but there was no teaching at King George Hospital, although trainees had stated that they would like to receive training there. The Queen's Hospital higher emergency medicine teaching timetable was well received, and had followed the same structure for a number of years which worked well.	The visit team recommends that emergency medicine trainees work on the Queen's site only (see action 1.1 above)	Recommendation
EM5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** The divisional director stated that the trainees received adequate training during the day, but the training overnight was insufficient due to the workload and clinical cover available. The divisional director commented that consultants should not assume that just because they were on the shop floor with trainees that the trainees were receiving adequate bedside teaching.	(see action 1.1 above)	

Good Practice	Contact	Brief for Sharing	Date
The ACCS and GP trainees would recommend to a colleague the training provided in anaesthetics, ITU and the GP training in the emergency department			
The ACCS trainees commended the supervision provided by the paediatric emergency medicine consultants and the ITU consultants.			
The higher EM trainees commended the breath of training opportunities provided by the case mix on the Queen's site, although the workload precluded them from taking full advantage if this.			
The visit team commended the Trust support for the future expansion of consultant numbers on the Queen's site.			

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*
Date:	*22 December 2015*