NHS
Health Education England

Developing people for health and healthcare

Quality and Regulation Team (London and South East)

Imperial College Healthcare NHS Trust
Western Eye Hospital
Ophthalmology
Specialty Focused Visit

Quality Visit Report

23 March 2016

Final Report

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Visit Details	
Trust	Imperial College Healthcare NHS Trust – Western Eye Hospital
Date of visit	23 March 2016
Background to visit	The Western Eye Hospital (WEH) had, historically, some seemingly intransigent issues relating to both education and service, which were having a detrimental impact on the quality of training the ophthalmology department could provide. The Specialty Focused Visit in June 2014 to the WEH found numerous issues that needed addressing, these included: the out of hours cover for casualty, consultant supervision, a lack of theatre exposure, the organisation of clinics and the lack of staffing to effectively manage the workload. There was a lack of engagement with the subsequent action plan from the visit in June 2014 and a meeting was held between the Trust and Health Education England North West London (HEE NWL) to ensure engagement and clarify measures of escalation if the issues in the action plan were not adequately addressed. This meeting in March 2015 provided stimulus to the department and there was progress made, unfortunately, the sustainability of this progress was not substantiated by the General Medical Council National Training Survey (GMC NTS) results in 2015, but instead confirmed a very poor training environment. The GMC NTS 2015 for ophthalmology at the Trust produced four pink outliers and four red outliers, which were 'clinical supervision out of hours', 'workload', 'access to educational resources' and 'supportive environment'. Following the results of the GMC NTS 2015, the specialty was placed in a status of enhanced monitoring by the GMC because the department had produced red outliers in the same indicators for four consecutive years. Further meetings were held between the Trust and HEE NWL but it was felt necessary in July 2015 to suspend training and start a phased withdrawal of trainees. This resulted in the removal of three trainees, a specialty training grade two (ST2), specialty training grade four (ST4) and specialty training grade six (ST6). The key lines of enquiry for the visit included: assessing the internal governance systems for serious incidents, the clinical supervision and support for trainees in theatres, clinics and casualty both in the day time, at weekends and out of hours, the training opportunities available, the existence of any bullying and undermining, the understanding of the educational faculty of the reasons leading to training suspension, and the support the department was receiving from within the Trust. There was a visit to the Trust in November 2015, but HEE NWL felt that it would be premature to assess the training environment after the Trust had begun to engage and develop the department. Therefore, it was felt that March 2016 would be an opportune time to review the department and assess the progress made by the Trust to the education and training environment of the WEH. This would enable an assessment of the sustainability of the progress made and review the position of trainees in the training environment.
Visit summary and outcomes	The visit team would like to thank the Trust for accommodating the visit and all who attended. This included the senior management team, the college tutor, clinical director, the consultant body, and the trainee body. The trainees the visit team met comprised specialty training grade one (ST1) to specialty training grade seven (ST7) trainees, some of whom held training posts within the Trust and others who held training posts in external trusts but were rostered on the Western Eye Hospital's emergency department out of hours rota. The visit team was pleased to find a department that had made significant progress since March 2015, and now provided a good learning environment for ophthalmology training. All the trainees the visit team met would recommend the Western Eye Hospital for training and noted the supportive and open atmosphere in the department. This had been perpetuated by an increase of consultants who were reported by the trainees to be proactive and encouraging towards education and training. The visit team commends both the college tutor and the director of medical education (DME) for their work to develop and professionalise the training environment, and this had been bolstered by the increased engagement and support from the wider Trust. It was evident that the department and Trust had

	worked together to develop clear lines of educational governance and although there were still improvements required in regards to minutes from local faculty groups and clinical governance meetings, the postgraduate medical education team were beginning to engage in this process. There were considerable improvements with clinical supervision in theatres and clinics, with structured support, controlled numbers of patients per trainee and protected teaching and feedback sessions with consultants. The clinical supervision within the emergency department during the day was very good and trainees felt supported during the nights, however, the position of ST1 trainees in the emergency department was questioned because of the inexperience and under confidence of the ST1 trainees. The Trust were looking at different options to bolster the confidence and abilities ST1s out of hours, but the visit team would encourage the Trust to work with HEE NWL on the out of hours rotas to provide a sustainable and beneficial option for training. The visit team was concerned to find a consenting process that although was robust with many safety checks there was still concern surrounding ST2 trainees performing the initial consent for complex cataract surgery. An immediate mandatory requirement however was not issued because of the consultant review of this decision later on in the patient pathway; however, ST1 and ST2 trainees did not have the relevant competencies levels to consent a patient unsupervised. The visit team concluded that although the progress made by the department was very good, however, the GMC enhanced monitoring status would be maintained until the sustainability of this progress could be proven. HEE NWL was however pleased to consider a phased reintroduction of the three training posts.

Visit team			
Lead Visitor	Dr Julia Whiteman, Postgraduate Dean, Health Education England North West London	**Trainee Representative**	Miss Karen Wong, Trainee Representative
Head of Specialty School	Miss Fiona O'Sullivan, Head of the London Specialty School of Ophthalmology	**General Medical Council Enhanced Monitoring Representative**	Alexandra Blohm, Education Quality Assurance Programme Manager, General Medical Council
Deputy Head of Specialty School	Miss Emma Jones, Deputy Head of the London Specialty School of Ophthalmology	**General Medical Council Enhanced Monitoring Representative**	Dr Jim Hall, Enhanced Monitoring Associate, General Medical Council
Lead Provider Representative	Dr Tim Gluck, Associate Director for Postgraduate Medical Education, UCLPartners	**External Clinician**	Professor Tom H Williamson, Consultant Ophthalmologists and Vitreoretinal Specialist
Lay Member	Kate Rivett, Lay Representative	**Scribe**	Lizzie Cannon, Learning Environment Quality Coordinator

Findings			
Ref	**Findings**	**Action and Evidence Required.** **Full details on Action Plan**	**RAG rating of action**

GMC Theme 1) Learning environment and culture			
O1.1	**Patient Safety** The visiting team discussed two almost identical serious incidents (SIs) arising from incorrect lens implantation that had occurred in May 2015 and January 2016. The visit team were concerned to hear that ST2 trainees took consent for complex glaucoma procedures. It would be unlikely that trainees at this level would be able to answer patients' concerns and questions relating to the procedure. This was because the specialty training grade seven (ST7) were still seeing patients in clinic and so left the consent to the ST2. However, an immediate mandatory requirement was not issued because the set procedure was for the consultant or ST7 to then review the consent decision before the operation. This safeguarded patient safety, but ST2 trainees must not be taking consent for such complex cases outside of their competency. Since the visit, the Trust assured the visit team that the ST2 trainee undertook a preliminary discussion with the patient, after this consent was gained by a higher trainee or consultant. The visit team heard that there was a process in place for choosing cataracts implants and ensuring this was correct for the patient. The trainees stated that the pre-operative planning sheet was undertaken by the ST1-2s, this was then reviewed by a higher trainee or a consultant before the operation and which was ensured with a counter signature on the consent form. On the day of the operation, the consultant undertook a ward round to review all patients. Before the operation, the visit team heard that there was a multi-disciplinary team meeting for all theatre staff where the list was discussed. The higher trainees confirmed that the implant, specific to the patient was the only implant within the theatre and this was picked out by the surgeon, against the planning sheet. The trainees did not report any concerns with the process and stated that it had been made far more robust as a result of the review of processes after the two SIs.	The Trust is required to review their consent processes in order to ensure that these are in line with General Medical Council consent and decision making requirements.	Mandatory Requirement
O1.2	**Serious incidents and professional duty of candour** The visit team heard that the Trust was implementing a standardised approach for clinical governance meetings and morbidity and mortality meetings to ensure consistent practice across the Trust. There had been considerable work carried out with the ophthalmology department to ensure the outputs from the governance meetings fed into the divisional clinical governance group. The Trust was assured that there were clear structures in place at a divisional level for collating, learning from, and escalating serious incidents. The Trust was providing additional administrative support to the department to ensure a good standard of minute taking in their governance meetings. The senior management team conceded that because the site was quite isolated, in comparison to the others within the Trust, this inhibited learning from serious incidents. However, the visit team were informed that there was a clinical governance newsletter shared across the divisions.	The Trust is required to follow up on the standard of minute taking and reporting from the governance meetings at WEH to ensure that learning points are captured and there is a clear documented audit trail for escalation and follow-up.	Mandatory requirement

	There were also minutes and information packs disseminated which included summaries of all near misses, serious incidents, and Datix reports. In addition, the higher trainees stated that serious incidents were incorporated into the protected teaching on Friday mornings. The visit team heard from the senior management team and the trainees that there were six governance feedback sessions per year, which included all regional trainees and provided learning from serious incidents. However, the medical director stated that the minutes from these meetings did not include the learning points and needed further improvement. This was a trust-wide project, not just specific to the ophthalmology department. The college tutor informed the visit team that the department had its own clinical handbook, which was continuously updated and reactive to serious incidents. This was available online and on a smart phone. The trainees stated that they knew how to report a serious incident through Datix and received feedback if they required it. The trainees stated that although they were not expected to fill in Datix forms, there was an open and supportive environment surrounding serious incident reporting within the department.		
O1.3	**Appropriate level of clinical supervision** The visit team heard from the senior management team and the consultant body that there had been increases in the department's ability to provide clinical supervision due to the increased numbers of consultants. This ability was confirmed by the trainees' comments of increased supervision across all areas within the department. The visit team heard that every clinic and operating list had a named consultant, as did the emergency department, who were the first consultant responsible for providing clinical supervision. The consultants did not take annual leave together which ensured there was consultants available in either the clinics or the emergency department and that the consultants were easily accessible and trainees always knew who the named consultants were. The trainees confirmed that there were good levels of clinical supervision during the day with consultants arriving at 08:00 and always present within the emergency department during the day. The core trainees stated that they had plenty of time to assess patients properly (between 10 to 15 patients every three hours) and had clinical decisions reviewed by a higher trainee or a consultant. The college tutor stated that consultants were not allowed to be taken out of a list, that there was a maximum of two trainees per list and that if consultant supervision was not available the list would be cancelled. The trainees stated that they felt there were good levels of clinical supervision within theatre, with either a consultant or clinical fellow present. Trainees stated that they would go through the notes and list before theatre and had not been asked to leave a list either. The visit team heard that there were now evening shifts 17:00 – 21:00, which provided additional support for the core trainees and had two higher trainees, one core trainee, a non-training grade doctor (normally the clinical fellow) and a consultant on call.		

	The senior management team stated that out of hours there was a core trainee, a higher trainee and a consultant on call. The consultants stated that the trainees knew who the on call consultant was at all times but that trainees would commonly call other consultants out of hours depending on the specialist nature of the case. The consultants stated that they would also be called by the on call consultant or higher trainee to discuss specialist cases, if they were the relevant specialist. The visit team heard that for major ophthalmology trauma the consultants stated they would come in out of hours, and this could be the consultant who was not specifically on call if it was a sub-specialty trauma. The consultants stated that they encouraged the trainees to participate in major trauma but that during the weekdays it was easier to facilitate this, because there were many people within the department and trainees and consultants could do trauma cases together. The visit team heard that access to trauma cases at the weekend had been increased due to the recent appointment (March 2016) of the onsite consultant on Saturday and Sunday. This had allowed trainees to go off site and access trauma because there was an additional level of cover. The department wanted to make this position a substantive post, not just sessional work. The visit team heard that the budget was being finalised to secure the funding for this extra consultant. The college tutor stated that the workload at the weekend justified the extra consultant and expenditure. The visit team were given assurances of the longevity and sustainability of consistent consultant presence at the weekends, with the clinical and management teams working together to align workforce and service demands. The visit team heard from the senior management team that the paediatric elective cases occurred at St Mary's Hospital, not the Western Eye Hospital. Paediatric emergency cases were brought to the Western Eye Hospital's casualty and made up approximately ten per cent of all cases. The visit team did find however that the trainees found the patient pathway for paediatric cases to be unclear. During out of hours the core trainees were encouraged and expected to call a higher trainee on call, not just for paediatric cases but also for all cases they needed support with. The core trainees confirmed that they were encouraged to call and would call the higher trainees to discuss cases. However, the college tutor stated that trainees were known to be reticent when calling a higher trainee because they were unaware if they needed to escalate the case to a higher trainee or consultant. This had resulted in larger numbers of patients being brought back for consultant review in the morning, to ensure patient care and safety. The higher trainees stated that there was a marked increase of calls from ST1s out of hours in comparison to the ST2s. The visit team felt uncomfortable that core trainees were placed in positions where there was ambiguity surrounding patient care and that this could be a potential patient safety concern.	The Trust is required to review and provide the patient pathways for paediatric and adult cases. This should include the roles and responsibilities of each level of trainee.	Mandatory Requirement
O1.4	**Responsibilities for patient care appropriate for stage of education and training** The visit team heard from the department that there had been various discussions and trainee engagement regarding the issue of core trainees, especially specialty training grade one (ST1) trainees providing care out of hours in the emergency department.		

	The senior management stated that they had received feedback that the clinical supervision and support out of hours for core trainees could be improved and that the higher trainees had highlighted issues when they reflected back on the core trainees' experiences out of hours. The visit team heard from the senior management that they had responded to these concerns and were trying to find a solution to increased support for core trainees out of hours. The college tutor stated that they had discussed with the trainees whether the ST1 should be taken off the out of hour's emergency department shifts all together, but the trainees had protested against this. This was because the trainee felt they would be missing a valuable learning experience, but also that the other trainees would have to increase their out of hour's commitments. The visit team heard from the higher trainees that the ST1 trainees were too inexperienced and under confident to be placed on the out of hours rota. The visit team heard that the college tutor was looking for locums to fill the gaps if ST1s were taken off the out of hour's rota. The visit team was interested to hear that the ST7 trainees did not have out of hour's commitments and felt that these trainees could be utilised out of hours. The idea of ensuring all core trainees had supervised sessions within the emergency department in hours before they started out of hours was considered. However, the visit team heard that this would not be possible because of the large number of trainees coming from external trusts who staffed the on call. The visit team did hear that the evening shifts 17:00 – 21:00 in the emergency department, which had an increased presence of higher trainees provided a supportive environment for core trainees to gain experience within the emergency department before joining the out of hours rota. The college tutor suggested that this could be extended to morning sessions too to ensure core trainees had suitable experience before out of hour's duties. This could be implemented in the local units too, who run daytime casualty and would reduce the travel time for trainees between sites. The visit team heard that the evening shift also reduced the number of cases core trainees were handed over for the out of hour's shifts. The average cases seen by each trainee out of hours was said to be approximately one to two patients per hour according to the consultants. At the time of the visit, (March 2016) core trainees started shifts, out of hours within the emergency department after three months within the department. It was suggested by the college tutor that this could be increased to six months and that there could also be a competency based threshold that had to be met by all trainees before working in the emergency department out of hours. The visit team strongly supports this initiative. The visit team heard that through these discussions, the agency of the decision-making had been placed with the trainees, and no concrete solution had been formulated, at the time of the visit. The visit team applauds and encourages high levels of trainee engagement regarding changes that effect training and education. However, it would also be prudent for the department to make decisions at a higher level and in consultation with HEE NWL, to establish a solution efficiently and with the best interest of the trainees represented.	The Trust is required to review the role of the ST1 out of hour's and assess how the ST1 trainee can be prepared before and supported when working out of hours alone in the Western Eye Emergency Department. The Trust is required to work with HEE to develop a suitable programme for all ST1 trainees on call. HEE strongly suggests putting ST1s on the out of hours' rota solo after 6 months WTE of supervised out of hour's experience.	Mandatory Requirement

O1.5	**Rotas** The visit team heard that the night shift pattern was changing for the core trainees (ST1-2s) from seven nights (Friday to Friday) on to a three and four nights pattern. At the time of the visit the college tutor stated that the out of hours commitment was one in thirteen, which allowed trainees to switch out of hours shifts when needed. The core trainees stated that they were rostered for one week of nights 21:00 – 08:30 Monday to Friday, followed by four days off. The director of medical education (DME) stated that trainees did come in on their rest days after working nights, but this was in no way encouraged by the Trust. The visit team was informed that there was a trust-wide group looking at all contracts for trainees alongside issues surrounding zero days. The visit team was informed that for these specific areas the ophthalmology department was not a particular issue, in comparison to other departments. The higher trainees stated that there was no pressure to come in if they had been called in out of hours and was at the trainee's discretion, whether they thought they were too tired or not. The higher trainees stated that there had not been a diary card exercise undertaken to ensure that the trainees' rotas were compliant with the European Working Time Directive (EWTD). The visit team heard that the department needed support and help regarding the North West London rotas for out of hours, especially when facilitating the lack of experience of ST1 trainees. There was also found to be a separate on call rota for the higher trainees to attend to cases outside of the Western Eye Hospital at the other sites of the Trust. The trainees stated that this used to be a different doctor every day, but this had become confusing and was changed to a full week, twice a year for each trainee. The higher trainees stated that the duties consisted mostly of giving advice down the phone but that the most calls came for St Mary's Hospital regarding paediatric cases and then the Hammersmith Hospital because there were no eye clinics. The latter could require the trainee to attend the site, this was rare, however when it did happen the trainee had to take all necessary equipment along with them. The higher trainees stated that the workload for this rota varied tremendously, and that when in theatre they ensured messages were taken by a non-scrubbed person who would escalate anything urgent.	The Trust is required to undertake separate diary card exercises for the core and higher trainees to ensure the rotas are EWTD compliant.	Mandatory Requirement
O1.6	**Induction** The visit team heard that all trainees in North West London who participated in the out of hour's service at the Western Eye Hospital received a full induction. This included being shown how to use the theatres and lasers by the consultants. The only difference the senior management stated was that internal trainees also received training on the CERNER and Medisoft software for use in clinics. The senior management team also stated that no matter what time the trainees joined in the year they would receive a full Trust induction and a local induction. The core trainees who held internal posts within the Trust stated that the induction was comprehensive and the majority of trainees at different trusts were released for the afternoon to attend the inductions. This was not the case for the trainees at Chelsea and Westminster Hospital		

	NHS Foundation Trust who were not released.		
O1.7	**Handover** The visit team heard from the senior management team that the ward round was conducted by consultants and involved the entire team. It was stated that this was programmed into the consultants' job plans. The trainees the visit team met with did not raise any concerns regarding the handover processes within the department. The core trainees stated that there was a special slot at 08:30 every morning where consultants reviewed patients who had been seen out of hours and were then told to come back in the morning. The trainees stated that this was around one in 20 patients and that they could stay and review the patient with the consultant, which was a valuable learning opportunity. The visit team was assured by the trainees that this was not mandatory and they were rostered to sleep after the night shift. The trainees stated that when out of hours patients were referred to external trusts, the trainee could call the trainee at the external trust and fax through the referral. The trainees stated that there were clear fax numbers for each trust and they knew who to call to confirm the referral paper work had been received.		
GMC Theme 2) Educational governance and leadership			
O2.1	**Effective, transparent and clearly understood educational governance systems and processes** The chief executive officer of the Trust stated that the Trust was placing increasing emphasis on education and training across the sites and specialties. This included analysing how service pressures were affecting training and education. The DME confirmed this approach and stated that this was the practice being implemented regarding the Health Education England North West London (HEE NWL) action plans, with good collaboratively working reported by HEE NWL. The visit team heard that one of the greatest enablers of change and improvement within the department had been the increase in staffing levels, enabled by increased Trust support for the department. The clinical director stated that through increased Trust support the department had been able to substantially increase the number of consultants, locums, and other health professionals. This had alleviated the workload pressures on the trainees, allowed for increased clinical supervision and support, and allowed for a more structured approach to clinics, enabling better training opportunities. The department had been unsuccessful recruiting nurse practitioners; however, the Trust had supported them by up skilling nurses internally. The visit team heard that it was predicted that these nurses would be available as fully functioning nurse practitioners by mid-2017. The visit team heard from the senior management team and education leads within the ophthalmology department that initially there had not been the engagement with HEE NWL to		

	provide evidence and instil confidence in HEE NWL that progress was being made. However, it was reported that the increased work of the postgraduate medical education team and especially the work of the DME had provided strong working relationships and structure to implement change and demonstrate progress within the training environment. The DME reported that since March 2015 the department had worked very hard to formalise the training environment. Training provided by the department, the DME stated was professional and provided by consultants who had total clarity regarding their educational and clinical responsibilities, and delivered on these.		
O2.2	**Opportunities for feedback** The visit team would like to commend the work undertaken by the department to increase conduits for trainee feedback and to provide support and anonymity when doing so. The college tutor stated that there were regular local faculty groups (LFGs) but also anonymous feedback opportunities, which were disseminated by a higher trainee to all trainees. The consultants stated that many of the actions produced from LFGs were service related and although had been discussed with managers had not been included in the LFG minutes formally. The visit team also heard that because the DME was external to the specialty it allowed for an additional and external conduit of feedback. The trainees confirmed the numerous conduits for anonymous feedback and felt the department was responsive and proactive to training needs and issues. The core trainees reported a very supportive environment where they felt listened to and had the opportunity to feedback anonymously. The higher trainees stated that there was a very good trainee representative who attended the monthly departmental meeting, raised training issues and cascaded information down to the trainee body.		
O2.3	**Systems and processes to identify, support and manage learners when there are concerns** The visit team heard that the department had a buddy system between the higher and core trainees which was not only useful to the trainees to provide support but for the higher trainees to learn to coach and mentor. The consultants stated that they were impressed by this system but that it was also bolstered by other, external and objective support that trainees could access if needed. The consultants also stated that within their meeting they discussed any trainees who had training issues and tried to identify trainees who might become trainees in difficulty. The visit team heard that because it was one consultant per trainee the amount of support they could provide was very high and tailored to the individual trainees' needs. The educational faculty should be congratulated for the organisation of educational supervision where each educational supervisor, supervises one trainee.		
GMC Theme 3) Supporting learners			

O3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The senior management team assured the visit team that the department and the Trust took bullying and undermining behaviour very seriously. The department was aware of the historical incidences of bullying and undermining and had put in place systems for anonymous trainee feedback, and was working on cultivating an open and supportive environment for trainees. The consultants stated that bullying and undermining issues would be reviewed by the head of service and passed on to the DME. This ensured externality and objectivity. There had also been multi-professional workshops to ensure staff were aware of bullying and undermining. The visit team heard that the method in which the department investigated bullying and undermining behaviour had changed. The DME was the responsible investigator and provided objectivity and externality to the process. All trainees stated that the department was a very supportive and open environment to work within. The higher trainees who had worked within the department in previous years commented on this change of culture and all trainees would recommend the post for training.		
O3.2	**Less-than-full-time (LTFT) training** The LTFT trainees the visit team met stated that they were very well supported within the department. The educational supervisors and college tutor were proactive and ensured that the trainees were able to have a health work-life balance while enabling adequate levels of training.		
GMC Theme 4) Supporting educators			
O4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The college tutor stated that one of the benefits of the increased consultant numbers was the ability of the department to provide one to one educational supervision between trainees and consultants. It was stated that this provided a nurturing and supportive environment for the trainees and allowed the educational supervisors more time to develop as trainers on training courses and for faculty development. The trainees reported that the increase in consultants had improved the department as a training environment because the new consultants were very supportive, proactive and enthusiastic regarding training and education. The visit team heard that the consultants valued being part of a larger cohort, as it provided them more time for teaching and training core trainees which was described as a challenging yet rewarding task. The educational supervisors confirmed that they received 0.25 programmed activities (PAs) per trainee within the job plan and the education and training part of their job plans were covered in their full scope of practice appraisal.		
GMC Theme 5) Developing and implementing curricula and assessments			

O5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** The visit team found that the rota matrix for trainees did provide good training opportunities, but still needed some improvements as one trainee was scheduled for two lists and a clinic in one day. The medical director stated that the department would be working closely with Health Education England (HEE) to ensure that the matrix rota provided curriculum coverage. The visit team heard from the college tutor that one of the impacts of the removal of the trainees had been the lack of supervising and mentoring opportunities for the higher trainees to the core trainees. All the trainees the visit team met with stated that the department would benefit from the additional trainees but they also reported the very good training opportunities available within the department at the time of the visit. The higher trainees reported an improved exposure to training opportunities and confirmed that they all attended two lists per week, with consultant presence. The visit team heard that the core trainees were supernumerary for clinics, with no patients assigned to them. The core trainees stated that this meant that there was no pressure to review a set number of patients and allowed for more learning time, on patients they did see, which was under consultant supervision. The core trainees confirmed that they did not run clinics by themselves. The higher trainees reported that clinic numbers were controlled well; the majority of the time and very few over ran. The corneal clinic was stated to overrun by 30 minutes and trainees would only be there until 18:00 if they were receiving a feedback session from the consultant. The higher trainees stated that they did not attend the community clinics, which were predominantly primary care and used to reduce the callbacks from casualty. The trainees stated that the clinics were well run and there was lots of space and slit lamps available. The core trainees did state that there were not enough slit lamps for the number of doctors within the emergency department but that the consultants or higher trainees would take patients to the outpatients' area. The core trainees stated that there were very good training opportunities available at the Trust and were able to meet the curricula requirements. The core trainees stated that the evening shift in the emergency medicine department was a positive learning and training environment. The visit team heard that the average number of patients each trainee saw out of hours was approximately 11, but this could increase to 30 patients for each trainee depending on the time of year and the day of the week. The visit team heard that despite the work of the triage nurses, who were put under pressure from patients to admit even if they did not meet the criteria, 50 to 60 per cent of cases that presented at the walk-in emergency department, did not need to be treated. The core trainees stated that there were good training opportunities in trauma, even though they did not leave the hospital. The core trainees stated that they would help prepare for the trauma	The Trust is required to ensure that all training posts within the ophthalmology department are able to provide training exposure that will ensure trainees adequately meet the curricula requirements. The use of evening clinics and / or theatre lists for training must be balanced by appropriate time and rest.	Mandatory Requirement

	but that they were all aware of the Trust policy that did not allow ST1 and ST2 trainees to go off site. The higher trainees stated that the increased number of consultants in the day had allowed the higher trainees to leave the site to access trauma cases, as this did not leave the other trainees with an unmanageable and unsafe workload. The higher trainees stated that learning from trauma was also enhanced by an increase in consultant numbers because they provided increased support and advice.		

Good Practice	**Contact**	**Brief for Sharing**	**Date**

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 Julia Whiteman, Postgraduate Dean, Health Education England North West London*
Date:	*6 May 2016*