QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

North Middlesex University Hospital NHS Trust

Emergency Department – medical posts

Urgent Concern Review

Quality Review report

Date: 20 June 2016
Version (if required): Final

Developing people
for health and
healthcare

www.hee.nhs.uk

THE NHS
CONSTITUTION
the NHS belongs to us all

Quality Review details

Background to review	This review is one of a number of reviews, visits and meetings that have taken place in regard to the Trust Emergency Department (ED) since July 2015. This report should therefore be considered alongside previous reports. Health Education England (HEE) conducted a conversation of concern at the Trust on 1 July 2015. Serious concerns were highlighted at the visit with regards to patient safety and the quality and delivery of education and training within emergency medicine. A subsequent informal meeting with trainees was organised for November 2015 where trainees interviewed appeared happier than they had previously been in July 2015, although problems persisted. Following the July 2015 visit HEE conducted a full review of health education and training in the Trust emergency department in March 2016. The March 2016 review uncovered a number of serious areas of concern and issued the Trust with three immediate mandatory requirements to address the following issues: • The visit team heard instances of foundation year two (F2) doctors, acute care common stem trainees (ACCS) and general practice (GP) trainees being left unsupported in the emergency department at night with neither middle grade nor senior on-site presence. • F2s, ACCS and GP trainees were frequently left in the paediatric emergency department with no competent senior support within the department, having had limited induction even before their first set of nights. • The visit team heard about items of equipment such as syringe drivers, infusion pumps, defibrillation pads, pulse oximeters, end-tidal CO2 monitors that were either unavailable or damaged and therefore not available for immediate use in the resuscitation area. A number of further serious issues were also identified. This report should therefore be read in conjunction with the report from the March 2016 review of the Trust ED. Following the March 2016 visit to the Trust significant work has taken place across the whole health economy in London, involving the Trust as well as commissioning and regulatory bodies. The main purpose of this review was to assess the current quality of education and training in the Trust ED, and the impact of changes made since March 2016.
Specialties / grades reviewed	Foundation year two trainees working within emergency medicine, general practice training working within emergency medicine and higher emergency medicine trainees.
Number of trainees from each specialty	On Sunday 19 June 2016 the visit team met with three foundation year two trainees, one general practice trainees and one higher emergency medicine trainee. On Monday 20 June 2016 the visit team met with six foundation year two trainees, four general practice trainees and one higher emergency medicine trainee.
Review summary and outcomes	The visit team found that whilst some progress had been made the areas of most concern identified in March 2016 remained. The current foundation year two trainees had rotated into the department in April 2016 and reported similar issues to those reported by trainees in March 2016.

	The three Immediate Mandatory Requirements from the March 2016 emergency department review were not met and remain open (see above). In addition to this the following was identified • Trainees continued to report being unsupported when there was a consultant or middle grade in the department. This was most frequently reported to be within resuscitation and the paediatric emergency department. • Trainees also reported being left unsupported in the emergency department. Two examples were provided where neither middle grade nor senior on-site presence for between one and two hours. • F2s, ACCS and GP trainees were frequently left in the paediatric emergency department without direct access to competent senior support within the department, due to the willingness of middle grade doctors and consultants to provide support to the paediatric emergency department. Some trainees reported having had limited induction even before their first set of nights and then working in this department. However trainees did report that the new paediatric consultant was having a positive effect when on shift. • There was still an issue surrounding lack of available equipment within the ED, however this equipment was different to the original deficits identified. No additional requirements have been placed on the Trust following this visit, and the requirements set in March 2016 remain extant. This report has been reviewed and agreed by the General Medical Council, who has confirmed that the findings of this report are fully endorsed by them as the independent regulator of postgraduate medical education and training in the UK.

Quality Review Team			
Lead Visitor	Professor Elizabeth Hughes, Director and Dean of Education and Quality, Health Education England London and South East	**HEE Representative**	Dr Sanjiv Ahluwalia, Postgraduate Dean, Health Education England North Central and East London
HEE Representative	Julie Screaton, Regional Director, Health Education England London and South East	**HEE Representative**	Ian Bateman, Head of Quality and Regulation, Health Education England London and South East
GMC Representative	Professor Ian Curran, Assistant Director for Education and Standards, General Medical Council	**GMC Representative**	Jessica Lichtenstein, Head of Quality Assurance, General Medical Council
Observer	Simon Weldon, Chief Operating Officer (London Region), NHS England (London Region)	**Observer**	Fran Davies, Deputy Director Clinical Quality (London), NHS Improvement
Observer	Professor Wendy Reid, Medical Director, Health Education England	**Observer**	Professor Ian Cummings, Chief Executive Officer, Health Education England
Scribe	Vicky Farrimond, Learning Environment Quality Coordinator		

Findings

GMC Theme 1) Learning environment and culture

Standards

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

Ref	Findings	Action required? Requirement Reference Number
EM 1.1	**Patient safety** All of the trainees within the emergency department (ED) reported that they had serious concerns about patient safety within the ED, particularly out of hours. None of the trainees the visit team met with felt there was sufficient staff numbers for the volume of patients attending the ED. The visit team heard numerous examples of patient safety potentially being compromised, as a result of a perceived dysfunctional department, the high volume of patients coming through the department, lack of suitable triaging and inconsistent senior support. The trainees at all levels reported issues regarding the competence of the Trust middle grade doctors whose capability they had little confidence in, and this led to a difficult working environment, particularly out of hours. Most trainees reported having to deal with situations beyond their competence without appropriate supervision on a regular basis – this was most often noted to be in resuscitation and the paediatric ED. The trainees reported being worried due to complex and unwell patients' presentations, the lengthy waiting time to be reviewed by a doctor and the impact this would have detrimentally on the patient. The trainees reported that the nurses were incredibly busy which resulted in them struggling to complete routine jobs let alone observations at agreed intervals on all patients within the ED to ensure they were stable – including those patients triaged but waiting to be seen. The trainees stated that the triage within the ED was unsuitable, many patients that required urgent doctor review were not prioritised or had an incorrect category placed against their name. The visit team heard that the process of moving patients between the Urgent Care Centre, and the see and redirect service did not always run smoothly, as trainees would often review a patient to then discharge them to find out the GP had already completed the discharge form for the patient already. The administrative processes supporting these two parts of the urgent and emergency care pathway at the Trust were unclear to the trainees. The trainees commented that there were major issues with triaging which had the potential to cause patient safety issues. Numerous examples were provided were patients had been triaged, had been directed to wait in the waiting room, and when they were later called to see the doctor had to be transferred straight to the resuscitation room due to their clinical presentation.	

The visit team heard that the trainees were concerned they were learning through experience, and were concerned that that which they were learning was not the correct treatment of patients, as there was no senior staff regularly available to discuss patients with, to enable the ED to be a learning experience.

There was variable access to equipment within the ED, the visit team heard that the ED had limited space to store equipment however trainees regularly had issues finding catheter kits, venturi masks, tendon hammers, peak flows, otoscope and arterial blood gas unit syringes. The visit team was informed that the resuscitation area was usually well equipped, there was reported issues if there was two crash calls within the same day as the equipment may have been used and not replaced.

The visit team heard of patients having to wait excessive amount of time for an electrocardiogram (ECG) despite the fact that 100% of patients presenting with chest pain should have an ECG within 15 minutes. The Trust have been working on this as part of the overall improvement programme in place however the trainees were clear that there was more that needed to be done.

The visit team heard that the flow of the department was ineffective and did not support patient care, the ED would regularly become bed blocked and patients either would not have a bed in which to be reviewed or would be in a bed in the department corridor. Trainees expressed that they spent 60% of their time trying to find somewhere to treat patients rather than actually delivering a clinical service to them.

The foundation year two (F2) trainees commented that they struggled to cope with the workload and patient complexities at the end of their F2 year and they did not think the ED would be suitable training location for a new F2 in their first rotation. The visit team heard that the core trainees are frequently left alone within the ED to manage difficult situations outside of their competence and would later be found to be very upset when a higher trainee was in the ED.

The GP trainees reported that recently stable patients from the ED had been taken to be reviewed in the acute assessment unit (AAU) which resulted in there sometimes being fewer patients waiting in the department.

The visit team heard that the computers within the ED tended to be slow or broken, the label printer did not work, there were usually not enough labels and trainees reported information technology (IT) system issues.

Concerns were also raised by trainees in regard to the governance of ECG reports and arterial blood gas reports. Trainees explained that a doctor had to sign off on a ECG, and that they would often be presented with an ECG report from a nurse to sign off, if they asked for the ECG to rerun this would not necessarily come back to them to sign off again, and at times it would go in to a pile of reports for a doctor to review. Likewise trainees described the system for reviewing arterial blood gas reports as ineffective – and provided examples where the reports had been placed in the bin, and had to be redone, or where the reports had not been reviewed and left in a pile next to the machine.

The visit team heard that higher trainees found it hard to deal with psychiatry patients at night as some patients abscond from the ED and the police would then be called. The trainees commented that these patients could be threatening towards staff and have in the past jumped on the nurses' station. The visit team heard that there was little to no teaching provided on how the trainees could look after and deal with these patients. Trust security provision was felt to be unsupportive and inadequate when handling these difficult cases and that whilst they were present in the department they were not able to or did not effectively assist in dealing with aggressive patients.

The higher trainees reported that at night the nurses would approach them with questions regarding patients they were triaging. The higher trainees reported that at night they would look at the patient screen and ask each trainee what they were doing with a patient, exploring and proactively agreeing the management plan. The visit team heard that the higher trainees rarely called the consultant at night to come into the department.

The visit team heard that the doctors in training were often overwhelmed by the volume and complexity of work and the lack of timely and competent clinical support and

	supervision. Higher trainees described how national guidelines were not being met or disregarded. It appears that the expected norm for clinical service had changed at the Trust as doctors felt it was acceptable for patients to be reviewed in seven hours and through this the staff within the department could be perceived as being blasé to how bad the clinical service had become within the ED.	
EM 1.2	**Serious incidents and professional duty of candour** The visit team heard that the foundation training programme director (FTPD) was available in the department once a week for the trainees to approach to raise concerns with. This was not always at a time when trainees were available to meet. The trainees reported that they would select which consultants they would approach to raise concerns to ensure the concerns would be addressed. The visit team was informed that the resuscitation officer was a good person for trainees to raise concerns with as they would actively be addressed and the resuscitation officer would encourage trainees to report these via Datix and would provide support and debriefing to trainees. The visit team heard that there was a monthly morbidity and mortality meeting which was linked into core trainees teaching. All doctors were not routinely invited to attend this meeting and many did not know if they occurred. The visit team heard that there was no meeting to discuss common Datix themes within the ED and learning from these incidents. The Trust report that these meetings occur, however it is clear that trainees do not consistently know that this is the case, and do not consistently attend. There was a clear sense that the department lacked robust clinical processes, governance and leadership. The visit team heard that the Trust could be doing more to prevent harm to patients within the ED and learning from incidents. The visit team heard of an serous incident (SI) being raised following an incident which could have been prevented, yet no changes had been made within the department and the SI still has not been closed seven months since the incident. There appears to be a disconnect between the views of trainees in regard to what constitutes a serious incident, and the view of the Trust. Appreciating that the definition is set nationally there is work to be done to support trainees to identify what is and is not a serious incident. Further there is a need to improve the processes in place to feedback and debrief trainees involved in clinical episodes that do not formally represent a serious incident, but are significant clinically and educationally nonetheless.	
EM 1.3	**Appropriate level of clinical supervision** The higher trainees reported that they knew who to contact for advice but that in hours it was unclear which area a consultant was responsible for. The higher trainees would often be responsible for running the ED out of hours. The visit team heard that if the higher trainees were on the night shift the department ran smoother, there was clear clinical leadership and the other trainees knew who to approach for support and advice. The visit team was informed there was a vast difference between the Trust middle grades doctors and locums compared to the higher trainees. The higher trainees reported that this was their first higher trainee job and it was “terrifying” at the beginning to be told they were the most senior person in the department out of hours with little to no handover or preparation. The trainees reported that they had little to no confidence in some of the Trust middle grade doctors. They reported that many Trust middle grade doctors were unfamiliar with resuscitation currently accepted clinical practice and guideline and trainees gave examples of inappropriate, unsafe sedation practices by Trust grade doctors. The visit team heard that a significant number of the Trust middle grade doctors were not advanced life support (ALS), advanced paediatric life support (APLS) or advanced trauma life support (ATLS) trained. It was reported that the Trust management had	

	been proactive about offering support and funding for the courses however not all middle grades had yet attended the training course. Information provided by the Trust however shows that all middle grades are ALS trained. The F2 trainees reported that depending on the Trust middle grade doctors on shift on a night would result in the varied provision of supervision to trainees. The trainees commented that locums rarely introduced themselves at the beginning of the shift which meant the F2 trainees did often not know who to approach if the locum was the middle grade that was meant to be providing them with senior supervision out of hours. The trainees reported that they would regularly be alone without supervision for "blue calls" within resuscitation; the trainees commented that some consultants would come and assist however this was rare and very dependent on the consultant on shift. The core trainees stated that they had to recognise if they needed support with a patient in resuscitation and to inform the consultant. However a number of examples were provided where trainees had to spend time finding the consultant even if they are meant to be on 'the shop floor'. Trainees reported being forced to make tannoy announcements to get supervision or support, or having to get consultants out of their office to come and help. Whilst the consultant offices are in the ED the accessibility of these doctors and their presence in a busy ED was reported to be incredibly variable and resulted in trainees spending time trying to seek clinical supervision and senior support. Examples were provided where even a tannoy announcement did not lead to consultants being available and often this resulted in the trainees contacting the medical or paediatric registrar for assistance. The trainees stated that some consultants were proactive in offering support to trainees in terms of patients they were reviewing, management plans and so forth. However the visit team heard that most consultants were still not consistently visible. The trainees commented that there was more consultant visibility on the shop floor in the daytime following the Health Education England (HEE) visit in March 2016. The visit team was informed that the supervision out of hours within paediatrics and resuscitation was deficient due to the Trust middle grade doctors actively avoiding these areas. Trainees stated they were reluctant to approach Trust middle grade doctors due to their reputation regarding clinical advice and support. The visit team heard that the locum consultants and Trust middle grade doctors would often pick patients to treat on the basis of a more simple clinical presentation, leaving the F2 and core trainees providing care for the more complex and challenging patients, which were harder to deal with, with limited supervision or support. The trainees stated that sometimes seeing a vast amount of complex patients made the night shift even more demoralising. The staffing at night was described as inadequate and trainees reported waiting times of up to eight hours. The visit team heard that the F2 trainee could often be the only doctor within majors and they would be keen for the clock to reach 8am so that more staff would arrive to review patients and provide support. The trainees reported that when they were within paediatrics out of hours, it would be difficult to find suitable Trust middle grade doctor support. The trainees had to call the paediatric higher trainee who was covering the whole hospital to ask for support. The visit team heard that a Trust middle grade doctor had said to a trainee who approached them for support and advice regarding a paediatric patient that "it is a clinical decision, you can make it". The GP trainees reported that during the day they would be able to find someone to provide them with supervision, although the trainees would be selective who they asked. The trainees reported that the support out of hours could be challenging, GP trainees felt that they are left unsupported within paediatrics and sometimes within majors. The trainees would be so concerned regarding the advice of the Trust middle grade doctors that they would approach another team within the Hospital. The visit team heard that on the out of hours rota the Trust middle grade rota had two shifts one was 11pm till 7am and the other midnight to 8am. The consultant would finish at 11pm; the visit team heard of two occasions when no one had arrived for the midnight shift this would mean that during 7am and 8am the F2 or GP trainee could be	

	the most senior person within the department. The trainees reported that some consultants lead the department very well when they are on shift and that the department is easier to work in when these consultants are on shift. The trainees were also very clear that the support from the paediatric consultant in the department is invaluable, and that the recent support from the doctor doing in reach from the medical assessment unit (MAU) was also making a positive impact.	
EM 1.4	**Responsibilities for patient care appropriate for stage of education and training** The F2 trainees felt out of their depth within resuscitation as they had to start, and complete, most “blue calls” alone. Trainees reported consultants and middle grades leaving resuscitation even when a serious blue call was incoming, or when resuscitation was full. Trainees reported trying to manage three blue calls at once without any support. Trainees consistently reported that they regularly felt out of their depth when dealing with patients. Whilst trainees agreed that the patient pathology was excellent, and the opportunities to learn from this were potentially vast, the lack of clinical supervision and professional support in actual training means that the potential for learning is lost.	
EM 1.5	**Rotas** The F2 and GP trainees reported that they had undertaken an hours monitoring exercise to ensure the rota was european working time directive (EWTD) compliant but that this did not have sufficient uptake to report. Trainees advised that the manner in which the exercise was run did not allow them to actually record the number of hours they worked and that they were restricted to only record the shift that they had been on. There was mixed reports from trainees in terms of the frequency at which they worked beyond their hours, with some saying this was rare. However the trainees stated that the problem with the rota was the length of time between finishing their shift and starting their next one (they would finish at 10/11pm and then have to start again at 8am or finish at 2am and be back in by 2pm) which is not EWTD compliant. Trainees advised that the rota was designed in a way that meant they could go from days to nights to lates all in one week. The higher trainees were regularly working overtime and staying late due to concerns regarding the unsafe nature of the department. The visit team heard that the rota was set six months in advance and that trainees were often asked to cover rota gaps, the department had tried to cover gaps through a local agency however they were often still left unfilled.	
EM 1.6	**Induction** The F2 trainees reported that the departmental induction was variable; the trainees were provided with information relating to the ED and some issues they may come across. The trainees would prefer to have had further time within the department to understand how it operated in terms of picking up patients, walking through the department and supervised time in the department to ensure trainees knew where relevant equipment and documents could be located. Trainees advised that the induction sessions delivered by staff from outside the department were markedly of a higher quality than those delivered by some of the ED staff. The F2 trainees stated that they were told about some of the problems within the ED at induction and the Trust strategies that were being developed. They valued this honesty from the Trust and found it reassuring when they first started having heard rumors. The GP trainees reported that all other trainees had a two day induction whereas they had only half a day. The visit team heard that the induction was disorganised and the day it was supposed to be on was altered which resulted in the GP trainees missing the GP mandatory teaching. The higher trainees felt that the departmental induction was not sufficient and did not	

	provide enough information. The visit team heard that the trainees were told incorrect information relating to ALS which did not comply with guidelines. The paediatric induction included a discussion regarding child protection and did not assist in preparing trainees for paediatric cases. There is a disconnect however between that which is recorded to have happened during the induction programme provided by the Trust, and the view of trainees. There is clearly work to be done in regard to the Trust seeking the views of trainees on the quality of the induction from both a content and delivery perspective.	
EM 1.7	**Work undertaken should provide learning opportunities, feedback on performance, and appropriate breadth of clinical experience** The visit team heard that it was not common for trainees to receive feedback on their performance and they would have to seek out feedback.	
EM 1.8	**Protected time for learning and organised educational sessions** The trainees stated that there was an absence of balance between service and education at the Trust. The F2 and GP trainees reported that they had only been able to attend around three departmental teaching sessions since starting in the ED. The visit team was informed that the departmental teaching was not compatible with the rota as the majority of trainees reported having Wednesdays off when the teaching took place. The GP trainees reported being able to attend departmental teaching but that this was following a night shift. Some trainees also reported that there were times when the person delivering the teaching did not arrive and that when this occurred they were sent back to the ED. They also reported that consultants would arrive to teaching who were not planned to be delivering it and that this resulted in an unstructured and unplanned session. The F2 trainees reported that the teaching they attended had been good, however they would prefer a more clinically focused teaching programme. The GP trainees reported that some speakers did not attend the teaching so that a higher trainee had to fill in and it was hit and miss if people attended or not. The trainees reported that they would get their half day release for GP teaching if they were working, they would be able to leave the department to attend however they would sometimes be late. The higher trainees reported that it was impossible for them to attend departmental teaching as there would not be any cover provided within the department. The higher trainees would instead provide support and cover to the core trainees. The visit team heard that there had been no formal departmental teaching programme since November 2015. The trainees reported that there was a good pathology mix at the Trust. The trainees stated they learnt through experience not active training from the ED.	
EM 1.9	**Adequate time and resources to complete assessments required by the curriculum** The F2 trainees reported that completing their workplace based assessments (WPBA) depended on the higher trainee or consultant that was available within the department. The trainees reported that there were limited opportunities to complete WPBAs and there was little support from consultants to complete these. The Trust has the potential to cover the vast majority of the curriculum for trainees however the trainees have little to no access to appropriate teaching or completing WPBAs.	

GMC Theme 2) Educational governance and leadership

Standards

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

EM 2.1	**Impact of service design on learners** The trainees reported that when they finished a shift at 2am they had no access to funding for a taxi home, for the trainees that don't drive this posed an issue as they were told not to walk around the area at night as it was not safe. The trainees reported that last train from Silver Street station was either 11:45pm or 12:05am. The visit team heard that trainees had requested to come on shift 10 minutes early to finish 10 minutes early to make the last train as they relied on public transport to be told this was not possible. The Trust report that appropriate provisions are in place to support staff to get home in taxis – however this is not clear to trainees. The trainees reported that they often had to change the beds within the ED before reviewing patients as they would have dirty sheets on them from the previous patient. Whilst it is recognised that there may occasionally be a need for this to happen this was seen to be representative of the overall level of work intensity and organisation of the ED. The trainees described spending vast amounts of their time finding somewhere to assess or treat a patient as opposed to actually treating them. The trainees reported that they had nowhere safe to leave their belongings and the changing rooms were for all staff they were not split into male and female. The trainees reported that the toilets were often unpleasant to use. The visit team was informed that no trainees would be happy with their friends or family being treated within the ED. The higher trainees commented that some trainees will call them to find out if they were in the ED before bringing in relatives. The visit team heard that many trainees came into the ED enthusiastic and were leaving deflated and "beaten down". The higher trainees reported that following the HEE visit in March 2016 there had been more paediatric support available as the winter pressure consultant had stayed at the Trust, although there was slight confusion over the consultants role at night and if trainees were still required within paediatrics.	

GMC Theme 3) Supporting learners

Standards

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good medical practice and to achieve the learning outcomes required by their curriculum.

EM 3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The visit team met with trainees who reported losing sleep and worrying about the care that the patients received. The trainees also reported that they sometimes found the whole experience of working within the ED and especially within paediatrics overwhelming and frightening. The trainees reported that they supported each other a lot to following the death of patients. The higher trainees praised their two clinical supervisors as being very	

	supportive. Examples were provided where trainees had been involved in serious incidents, or distressing cases but were not provided with any debriefing or support, or were not able to attend debriefing led by the relevant specialty e.g. paediatrics, as they were the only doctor covering a certain part of the department.	
EM 3.2	**Behaviour that undermines professional confidence, performance or self-esteem** Trainees at all levels reported that at times the atmosphere in the department was not conducive to a supportive working environment. Trainees gave examples of recent instances when they had felt bullied, when consultants had shouted at them in public areas and when doctors and nurses had behaved in a way that they felt undermined, demoralised or humiliated. Further detail on this has been provided in confidence to the Trust Medical Director. Trainees reported having been shouted at in front of patients, medical and nursing colleagues; they also commented that feedback from consultants was not always constructive. The trainees also confirmed that they had been allocated a neutral mentor from another Trust who was very supportive. Trainees at all levels confirmed that they had learned who to approach for advice and who to avoid. However, they commented that they felt at times ethically challenged since they had to choose between following advice that they perceived to be potentially inappropriate from a senior clinician or follow their own clinical plan or seek clinical advice from outside the ED. The F2 trainees felt that when they had suggested alternative treatment to some of the consultants, their suggestions had been met with a strong, negative response but was later confirmed as correct by the relevant specialty. They often feared that they were learning the incorrect method of dealing with patients. The trainees all stated that the ST4 emergency medicine trainees were very supportive and went above and beyond their normal duties and working hours to support them and the department. The visit team heard that out of hours some trainees were intimidated by patients, relatives and nurses within paediatrics and that the security provided by the Trust was not effective.	
EM 3.3	**Access to study leave and annual leave** Trainees at all levels reported that study leave and annual leave was rostered into their rota. The trainees reported that they could change study leave and annual leave if required, although this took a lot of effort on their part. Trainees reported that study leave is often rostered on their zero day, so they were not actually getting their zero day. Trainees also reported that when trainees do manage to change their study leave or their annual leave a locum is not always booked, or the rota is not amended meaning that there is an additional unplanned gap on the rota. Trainees reported waiting to handover to someone who was on annual leave or study leave.	
GMC Theme 5) Developing and implementing curricula and assessments		
Standards **S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.** **S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.**		
EM 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** See section EM1.8 above.	

EM 5.2	**Sufficient practical experience to achieve and maintain the clinical or medical competences (or both) required by their curriculum** See section EM1.9 above.	

Good Practice and Requirements

The current requirements from the March 2016 emergency department review remain in place and no further requirements were set following this review.

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
Health Education England to provide details of behavioural concerns to the Trust Medical Director in confidence.	Ian Bateman – Head of Quality and Regulation – HEE London and the South East
Health Education England to provide details of clinical incidents that were reported during the visit to the Trust Medical Director.	Ian Bateman – Head of Quality and Regulation – HEE London and the South East

Signed	
By the Lead Visitor on behalf of the Visiting Team:	 Professor Elizabeth Hughes Director and Dean of Education and Quality HEE London and the South East
Date:	23 June 2016