QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

London North West Healthcare NHS Trust

Emergency Medicine and Acute Care Common Stem

Risk-based Review (on-site visit)

Quality Review report

Date: 07 July 2016
Version: Final

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Quality Review details

Background to review	London North West Healthcare NHS Trust was established in October 2014 and comprises Northwick Park Hospital, Ealing Hospital, Central Middlesex Hospital, and St Mark's Hospital. The latter two hospital sites did not have emergency departments while the two former did. Northwick Park Hospital had the larger of the emergency departments and had considerable resources assigned to it, to ensure the department could meet the demands of the service. The two emergency departments have both had their training environments reviewed in the past three years on separate occasions. Northwick Park Hospital's emergency department was reviewed in April 2013 and Ealing Hospital's emergency department was reviewed in May 2014. The latter's action plan still has multiple actions open and the visit team was concerned that this lack of engagement and progress was symptomatic of a lack of support within the Trust and difficulties within the department. The review team therefore wanted to review the training environment at Ealing and assess how the department could be supported to improve education and training. There have also been major service reconfigurations within the North West London sector and the Review needed to assess the ramifications on the training environment and the ability of trainees to attain their training competencies in both emergency medicine and acute care common stem (ACCS) training programmes. At Ealing Hospital the labour ward had closed in 2015 and inpatient paediatrics closed in June 2016. Both sites also had urgent care centres (UCCs) on site and the visit team wanted to review whether trainees still had access to minor injuries and illness cases. The General Medical Council National Training Survey (GMC NTS) results for 2015 in ACCS provided one red outlier in 'access to educational resources' and two pink outliers in 'clinical supervision' and 'clinical supervision out of hours'. The results for emergency medicine were all white, except for one pink outlier in 'clinical supervision'. These results however, were generated across the Trust and were not site specific, the review team thought it prudent to review both Ealing Hospital and Northwick Park Hospital to further highlight the issues in each department and assess how joint working between departments could ameliorate some of the effects of the service reconfigurations.
Specialties / grades reviewed	The visit team met with higher and core trainees at both Ealing Hospital and Northwick Park Hospital. The trainees were from the higher emergency medicine training programme, Direct Route Entry into Emergency Medicine (DRE-EM) programme and the acute care common stem (ACCS) training programme. The ACCS trainees' parent specialties were in emergency medicine and anaesthetics, but as a trainee cohort, they had experience in all four specialties: emergency medicine, anaesthetics, intensive care medicine and acute medicine.
Review summary and outcomes	The review team would like to thank all those who attended the visit, although they were disappointed at the limited turn out of faculty at Ealing Hospital. This was a concurrent theme for all the risk-based reviews that took place at Ealing Hospital. The review team found that at both sites the UCC was impeding trainees' ability to attain competencies in minor injuries and illness. The Trust should look to engage more with the UCCs to ensure that trainees can benefit from this environment, not as an observer but as a clinical practitioner. The review team was displeased to find, that apart from in anaesthetics, collaborative working between the two hospitals was limited. This was preventing trainees from optimising the training environment that the Trust provided. The visit team highlighted that the emergency department at Northwick Park Hospital was not optimising the simulation facilities on site, but the appointment of a simulation fellow across the two departments would be an excellent initiative of joint site

working. The visit team would also recommend a joint department recruitment strategy between the departments. The visit team would like to commend the work of the college tutors at Northwick Park and Ealing Hospital for emergency medicine and ACCS and would like to see closer working between the two consultant faculties.

Ealing Hospital

Increased collaboration would also ameliorate the significant limitations of the training environment for the emergency department at Ealing Hospital. The lack of substantive consultants within the emergency department was detrimental to the structure of the faculty and the teaching that could be provided, educational supervision levels, and most saliently the level of direct clinical supervision the trainees could receive. The visit team found, that at the time of the review, the consultant workload and rotas were unsustainable.

The visit team found that the closure of the inpatient paediatric services and the labour ward at Ealing Hospital had ensured that the site could no longer provide training competencies in paediatrics and prevented trainees from maintaining these competencies, whether in emergency medicine or anaesthetics. The visit team found that there had been little done to find alternatives for training in paediatric skills. The visit team also found that due to the surrounding emergency departments in the sector, Ealing did not provide exposure to enough trauma or acute cases to provide training opportunities for ACCS trainees and emergency medicine higher trainees to attain their training competencies. This had resulted in trainees failing to achieve an outcome one in their academic review of competency progression (ARCP).

The visit team found that there were serious concerns regarding the competence of the middle-grade trust doctors who worked within the emergency department at Ealing Hospital. The visit team were informed that patient safety concerns were offset by the senior support and care provided by the other specialties. The visit team felt that the paediatric pathway implemented for walk-in paediatric cases to Ealing Hospital was adequate but could potentially be undermined due to the lack of doctors trained in advanced paediatric life support (APLS) skills.

At Ealing Hospital, the visit team found that training in anaesthetics for ACCS trainees was good. The intensive care medicine rotation for ACCS trainees was also described as good, as was the acute medicine rotation in infectious diseases. However, the trainees described the three months of the acute medicine rotation for ACCS in cardiology as poor and the faculty lacked any comprehension of the training needs of ACCS trainees.

Northwick Park Hospital

The visit team found that in contrast to Ealing Hospital, the training environment at Northwick Park Hospital was very good. There were substantial numbers of consultants to undertake clinical work and provide clinical supervision seven days per week. Although, there were reports that service provision could inhibit informal direct teaching from consultants or access to ultrasound training and caused delays in receiving sign off on workplace-based assessments.

The visit team found good practice in the acute medicine ACCS rotation with two months experience in the high dependency unit (HDU) which was excellent for developing ACCS competencies. The acute medicine, intensive care medicine, and anaesthetic rotations were all deemed very good for ACCS training. With a faculty of consultant that was engaged and aware of ACCS training competencies.

Good practice was also found in the flexibility of the emergency medicine rota at Northwick Park hospital. This however, was not the case for the acute medicine rota, which needed addressing urgently.

Other areas that needed adjustment and improvement included the attendance of trainees at meetings for clinical governance and at local faculty groups, the teaching programme for middle-grade doctors and the equitable distribution of trainees across the trainers for education supervision.

There were no patient safety concerns raised by the trainees or consultants for the

	Northwick Park Hospital site. However, the trainees did state that the competence of the trust-middle grades could vary, but still ensured patient safety. Overall, the training environment at Ealing needs additional support from the Trust, not just for training and education but also to meet the service demands while maintaining patient safety. The training environment has been severely limited by the reconfigurations in the area and the Trust must look at a far more collaborative approach, with the robust and rich training environment or Northwick Park Hospital to ensure the training environment at Ealing Hospital can be maintained.

Quality Review Team			
Lead Visitor	Dr Chris Lacy, Head of London Specialty School of Emergency Medicine	**External Representative**	Dr Jamal Mortazavi, Emergency Medicine Consultant, College Tutor
Trust Liaison Dean	Dr Orla Lacey, Trust Liaison Dean, Health Education North West London	**External Representative**	Dr Hilary Connor, Training Programme Director, North Central East London
Lead Provider Representative	Dr Ruth Brown, Emergency Medicine Consultant, Specialty Lead Health Education North West London	**Trainee Representative**	Dr Matthew Mak, Trainee Representative, North Central East London
Lay Member	Kate Rivett, Lay Representative	**Scribe**	Lizzie Cannon, 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
EMA CCS 1.1	**Patient safety** **Ealing Hospital** The visit team heard that the trainees had serious doubts regarding whether they would send their friends and family to be treated within the emergency department at Ealing Hospital. They would however feel confident for their family to be treated by the anaesthetic and medicine departments. <u>Clinical competence</u> The visit team heard from the trainees that the only reason why their concerns regarding patient safety within the emergency department at Ealing Hospital had been	

	quelled was due to the intervention of the medical specialties. They were described as being very supportive, effective and ensured the timely treatment of patients within the emergency department. It was reported to the visit team that the timely intervention and support of the medical specialties ameliorated the lack of clinical competence within the middle-grade trust doctors. The visit team heard that there were serious concerns regarding the competence of one of the middle-grade trust doctors; this was confirmed by all the attendees the visit team met. The college tutor stated that the majority of the middle-grade trust doctors were competent and their continued employment was preferable than hiring more competent doctors who were not as au fait with the department. To develop the middle-grade trust doctors the department provided them with clinical supervisors and were developing their skills and confidence to better serve the department and ensure patient safety. There was a lack of clarity as to whether the middle-grade trust doctors had advanced life support skills. In contrast, the trainees stated that the middle-grade trust doctors lacked confidence in clinical decision making and would refer patients to specialties to avoid having to make difficult clinical decisions. The visit team heard that the trainees, even if they were specialty training year one (ST1), often felt like the most competent doctor in the emergency department out of hours. It was reported that on one occasion when the higher trainee (or equivalent trust-grade doctor) in anaesthetics was not available, the ACCS trainees in emergency medicine were left to stabilise and manage the airway of a seizing patient. This was because the middle-grade trust locum doctor (the senior clinician) was unable to manage the situation. The visit team heard that no one at the time of the incident had training in seizure management. The visit team also heard that the middle-grade trust doctors' inability to make clinical decisions delayed patient discharge. Instead of making the discharge decision the patient would be admitted to the clinical decisions unit (CDU) to ensure the emergency department did not breach the four hour quota; hence the reference to the CDU as the 'clinical dumping unit'. The trainees also stated that this occurred for patients unnecessarily admitted onto the medical wards, because the medical doctors were very busy dealing with other calls and patients in the emergency department, along with the patients on the medical wards. The discharge decision was not made in the emergency department, so the patient was admitted and discharged later. The trainees stated that if this occurred on a Friday the patient would normally stay over the weekend. <u>Paediatric pathway</u> The inpatient paediatric services at Ealing Hospital closed in June 2016, which also meant that the emergency department at Ealing Hospital would no longer receive paediatric emergency patients, including blue light paediatric calls. However, it remained possible that paediatric walk-in patients could still present at the emergency department. The college tutor stated that there had been a few paediatric cases per week, since the last visit. The visit team heard that the central alerting system (CAS) no longer sent paediatric cases to Ealing emergency department and there was a paediatric patient pathway that had been circulated regarding the procedure if a 'walk-in' paediatric patient arrived at the emergency department requiring resuscitation. The visit team was also informed the Ealing Hospital UCC would only refer paediatric resuscitation cases to the Ealing Hospital emergency department and all other paediatric cases would be referred to Northwick Park Hospital. The college tutor stated that because not all staff in the department were trained in advanced paediatric life support (APLS) the consultants were responsible for the paediatric resuscitation cases and a blue light call would be made to transfer the patient to either Northwick Park Hospital or St Mary's Hospital (part of Imperial College Healthcare NHS Trust). This pathway had gone through a clinical governance risk review by one of the emergency medicine consultants at Ealing Hospital. The trainees confirmed this pathway but added that if the patient was a level three the patient would be transferred via CATs but if a level one or two severity patient a blue	Yes, see below EMACCS1.1a

	light call would made to transfer the patient to Northwick Park. The visit team heard that although there were no paediatric consultants on-site, the trainees stated that they trusted the majority of the anaesthetics department for airway management, but most definitely the ITU department doctors for paediatric airway management. The visit team heard that during the day while there were paediatric consultants on-site for the outpatient clinics, they were available for advice and could attend a paediatric cardiac arrest. **Northwick Park Hospital** The visit team heard that the non-training grade middle-grade rota for the emergency department contained doctors of varying standards, but that the college tutor and clinical lead were not concerned that this was detrimental to patient safety or education and training. The visit team were assured that all the middle-grades had up-to-date advanced life support and APLS courses. The trainees stated that there were varying degrees of competence with the middle-grades but that they did not have any patient safety concerns.	Yes, see below EMACCS1.1b
EMACCS 1.2	**Serious incidents and professional duty of candour** **Ealing Hospital** The college tutor stated that the Datix system was used to report serious incidents and that the college tutor and educational supervisor would be informed if this involved a trainee. The college tutor stated that there was a daily update email with all the serious incidents, but that there were occasions where the college tutor was not aware of serious incidents within the emergency department. The college tutor also conceded that if a serious incident was reported on a medicine ward but which related to the emergency department the college tutor would not be aware of this until they asked for a statement. It was also reported that there was no defined person within the emergency department that was responsible for monitoring any serious incidents or anyone who had a defined clinical governance lead role. It was stated that the serious incidents were all collated and discussed at a monthly clinical governance meeting for all of medicine and emergency medicine, although it was reported that this meeting could often be cancelled because nobody attended. The college tutor also stated that there was a monthly morbidity and mortality (M&M) meeting; for both meetings the emergency department were expected to present cases. It was reported that the trainees were invited to attend the clinical governance and M&M meetings but that they rarely attended. Apart from these two opportunities there was no other instance where learning from serious incidents occurred. The visit team was informed by the trainees that when they had submitted serious incidents via Datix they had received no feedback although with certain issues such as access to 'Omnicell' machines or fixing printers the response was quite efficient. The trainees also stated that they had not submitted their concerns regarding the competence of the middle grades, but had voiced this verbally to the department lead. They perceived that their concerns were not acknowledged or taken seriously. **Northwick Park Hospital** The visit team heard that serious incidents were discussed at clinical governance meetings and M&M. The college tutor stated that the trainees were invited to these meetings but if they could not attend then there was a newsletter emailed to all trainees detailing serious incidents and learning from them. Additionally, there was a morning communication meeting in the emergency department, every morning where learning from issues was discussed. The trainees stated that they did not always receive feedback from Datix submissions, although they did state that the newsletter discussed learning form serious incidents and morning meetings. The trainees stated that they wanted to attend M&M's and clinical governance meetings, which was not feasible at the time of the visit. The visit team did hear from the trainees that in all specialties for ACCS the trainees would appreciate more informal, face to face feedback either in person or via Skype. The trainees stated that support and feedback they received form consultants varied	Yes, see below EMACCS1.2a Yes, see below EMACCS1.2b Yes, see below EMACCS1.2b Yes, see below EMACCS1.2a

	widely across the consultant cohort and in the past had proved lacking in certain situations.	
EMA CCS 1.3	**Appropriate level of clinical supervision** **Ealing Hospital** Within Ealing Hospital's emergency department the college tutor stated that there were two substantive whole time equivalent (WTE) consultants, and an additional two long-term locum consultants. There had been attempts to recruit to a fifth consultant position, but this had failed, although there was an associate specialist who was also on the consultant rota. The visit team heard that clinical supervision was allocated in the job plan, with a 75 per cent split for clinical and non-clinical work; this was the same for substantive and locum consultants. The visit team was concerned to hear that none of the locums within the emergency department were registered as a Fellow of the Royal College of Emergency Medicine, and how this would impact on their ability to undertake clinical supervision responsibilities. The visit team heard the minimal number of consultants meant, that the two WTE substantive consultants were second on-call on alternating weeks and the other week resident on-call, with the other consultant positions being placed as the first on-call for out of hours duties. The college tutor stated that the consultants were in the department on weekdays from 8am to 10pm and on the weekends from 8am to 2pm. The visit team was concerned that the consultant rota was unsustainable and was detrimental not only to the well-being of the consultants but to the education, training and clinical supervision they could provide the trainees. The college tutor did not share these concerns. The trainees confirmed that although the consultants worked these hours they were had minimal presence on the shop floor providing direct clinical supervision and support. The trainees, the visit team met with, stated that the majority of specialty training year one (ST1) trainees and foundation year two doctors did not receive consultant supervision. The visit team were informed that out of hours the clinical supervision the trainees received varied greatly. The ACCS trainees who had worked in the emergency department at Ealing Hospital stated that the best source of supervision, leadership and direction within the department were the higher trainees in emergency medicine. The ACCS trainees who had worked within the anaesthetic department at Ealing Hospital stated that they received excellent clinical supervision. The college tutor for anaesthetics stated that the ACCS trainees in anaesthetics did not attend on call for three months (as they were supernumerary) and then after the three months and an assessment of the trainee's competence the trainee would be placed on call but with a higher trainee, or equivalent trust-grade doctor. The trainees confirmed this arrangement and stated that there was always a core trainee and a higher trainee working alongside each other; this provided good supervision. The clinical supervision for the acute medicine rotation of the ACCS programme was described as variable. The cardiology cover was weak, but the clinical supervision for the acute medicine take and in the infectious diseases department was very good. The trainees stated that radiology reporting was good, although the radiologists would prefer to report to a higher training grade (or equivalent trust-grade), reporting was still efficient. The trainees also stated that there was 24/7 consultant cover at Ealing, which was very supportive. **Northwick Park Hospital** The visit team were informed that there were 13.5 WTE substantive consultants within the emergency department at Northwick Park Hospital. The majority of the consultants were on the specialty register, or certified as a Fellow of the Royal College of Emergency Medicine. Three of the consultants were on the specialty register, although they had studied their undergraduate medical education abroad and five of the consultants had attained their certificate of completion of training (CCT) within five	Yes, see below EMACCS1.3a Yes, see below EMACCS1.3b

	years. The college tutor stated that the consultants were allocated approximately 60 to 65 per cent within their ten PA job plans for direct clinical care. The visit team heard that with this the department was able to provide consultant cover from 8am to midnight, seven days per week. The visit team heard that out of hours the trainees were encouraged to refer to the substantive middle grade trust doctors and not the locums, within the emergency department. This was because although there were no serious concerns over the latters' competence the former could provide better clinical supervision to trainees. The trainees confirmed that there were some middle-grade doctors that they would not refer to or seek out clinical support from, because of their competence levels. The trainees stated that at night, out of hours, this could be especially difficult, depending on the middle-grade on shift. However, the trainees stated that this effect was ameliorated as there was normally a good mix of staff on shift with good levels of clinical knowledge and could support the trainees. The consultants also stated that they expected and encouraged the trainees to come directly to the consultants if needed and that the consultants were constantly supervising the trainees and discussing each case with them. The trainees confirmed that the consultants were all approachable and would come and review a patient with a trainee, but only after a little bit of persuading, but all stated that they would discuss discharge decisions with a consultant. They stated that this might be slightly intimidating for a foundation year two doctor to do so, and the trainees at the visited theorised this probably explained why the foundation year two trainees sort out the ACCS and emergency medicine trainees for clinical support rather than the consultants. The visit team heard from the college tutor for emergency medicine that ACCS trainees with anaesthetics as their parent specialty would start their rotation in anaesthetics first to ensure they learnt the anaesthetic competencies and went on the novice anaesthetist course. The trainees also stated that they never did on call out of hours in anaesthetics and received excellent supervision within their rotation. The ITU rotation was described by the ACCS trainees as well supported and with constant consultant supervision and direct phone support out of hours. The trainees confirmed that there was always a doctor present who had airway skills and they were supported by the anaesthetics higher-grade trainee too. The trainees also stated that because they had experienced the HDU first in the acute medicine rotation, they had already attained many useful and applicable skills for working within ITU and this also helped them boost their confidence.	Yes, see below EMACCS1.1a
EMACCS 1.4	**Responsibilities for patient care appropriate for stage of education and training** **Ealing Hospital** The visit team heard that there was a tendency for staff in the emergency department to assume that the competence of a specialty training level three (ST3) trainee was of a higher trainee standard, than the actual core training level standard. However, the visit team heard that the majority of the time the core trainees were treated like foundation year two trainees but then out of hours if the trainees were on a shift with the locums, the trainees were expected to run the department. Additionally, out of hours the nurses would approach the ST3 trainees, instead of the locums. **Northwick Park Hospital** The ACCS trainees stated that when they are working within the emergency department they are commonly mistaken for higher trainees and asked to undertake task outside of their competencies; such as signing off echo cardio grams. The trainees stated that they would prefer a discrete ACCS rota, which had been in use when they first started their ACCS training programme at the Trust.	Yes, see below EMACCS1.4

EMA CCS 1.5	**Rotas** **Ealing Hospital** The college tutor stated that the gaps in the rota were a chronic problem, and would become worse as the department had not been allocated any higher trainees in emergency medicine in October 2016, which would mean that the eight slot rota would be missing the two higher trainees, and only have one permanent middle-grade trust doctor and five locum middle grade doctors. However, the college tutor assured the visit team that because of the number of consistent, experienced locums, who knew the department very well, the service was covered and worked well. It was also added that the Trust supported the department in financing the locums and the administration and organisation of the middle-grade rota was undertaken by a specific administrator. The visit team heard from the trainees that the emergency medicine rota was an 'A to O' rota which meant the trainees' shift pattern changed every week and was heavily stacked to cover out of hours shifts. The trainees stated that there was only one grade rota which combined the foundation year two, core and higher trainees in emergency medicine and the ACCS trainees in emergency medicine. The emergency medicine rota was described as bad and grueling and was reported by the trainees to be the reason, combined with limited senior or consultant supervision why none of the foundation year two doctors would contemplate emergency medicine as a future specialty. The ACCS trainees were all content with the rotas for acute medicine, ITU and anaesthetics. **Northwick Park Hospital** The college tutor for emergency medicine at Northwick Park Hospital stated that at the time of the visit the middle-grade rota was at an 80 per cent fill rate, with four of the five training posts filled. The department had no concerns regarding the fill rate, after the effect of trainee rotation in August and October 2016. The trainees however did raise concerns that there were a large proportion of gaps within the middle-grade rota, which was not filled by locums. The visit team heard that there was a large middle-grade rota in operation at the time of the visit, which the foundation year two trainees, the ACCS trainees and the GP trainees were on. There was then a separate higher rota. The visit team were informed that there were plans to reconfigure the rotas and include a two tier higher rota to improve clinical supervision levels, by paring less experienced doctors with more experienced doctors, especially overnight. All the trainees that the visit team met at Northwick Park stated that the rota for emergency medicine was excellent and very flexible to allow for study and annual leave. This was also the case for anaesthetics and ICM, although the trainees stated it was more difficult to receive study leave in ICM when on nights. Unfortunately, this was not the case for the acute medicine rota, which was described as very tight, inflexible and did not allow study leave to be taken within a two-month block. This had resulted in trainees studying on their zero days. The visit team was also concerned to hear that compassionate leave or annual leave could not be taken easily. This had resulted in one trainee unable to attend the funeral of a close family member. The trainees stated that you could only get a day off if you were able to swap with someone else but the rota was so tight, that it was nearly impossible. The acute medicine rota was also described as being inhospitable to less than full time trainees.	Yes, see below EMACCS1.5a Yes, see below EMACCS1.5b Yes, see below EMACCS1.5c
EMA CCS 1.6	**Induction** **Ealing Hospital** The visit team heard that the local induction of the emergency department at Ealing Hospital was comprehensive, which involved a tour of the department, passwords, IT systems and a tour of the library. This was not mirrored in the Trust induction, which was held once a month, and ran for a whole day. However, this meant that trainees could wait numerous weeks to receive a trust induction, which involved safeguarding courses and did not involve how to deal with emotionally erratic patients. The college tutor at Ealing Hospital agreed that this would be very useful content.	Yes, see below EMACCS1.6

	Northwick Park Hospital The trainees the visit team met at Northwick Park Hospital did not raise any issues regarding the Trust or local inductions in emergency medicine, acute medicine, ITU or anaesthetics.	
EMA CCS 1.7	**Handover** **Ealing Hospital** The visit team heard that Ealing Hospital and Northwick Park Hospital emergency departments used the same IT system, 'Symphony'. However Ealing Hospital's inpatient tracking system was done via 'E-pro' but that this was not used in the emergency department. The acute medicine consultant confirmed that patients from the emergency department were easy to track and the handover system in acute medicine was robust. None of the trainees, the visit team met at Ealing Hospital, raised any concerns regarding the handover systems of any of the departments: acute medicine, anaesthetics, emergency medicine and intensive care medicine. **Northwick Park Hospital** The college tutor for emergency medicine at Ealing Hospital stated that there was a medical handover in the morning but that the department would like to have night time handover at 23:30 but this had not be successfully implemented. The trainees stated that because the shifts were staggered in the emergency department the handover was undertaken on a one to one basis during the day but that there was the morning handover, where issues, staffing and patients were discussed. The trainees stated that they would appreciate a system, or just a printed list that allowed them to identify who was the named consultant for each area in the emergency department on the day, instead of just finding out organically.	Yes, see below EMACCS1.7
EMA CCS 1.8	**Protected time for learning and organised educational sessions** **Ealing Hospital** The visit team would like to commend the work of the college tutor for developing the ultrasound teaching which was found to be much improved from the previous visit in May 2014. However, the college tutor stated that the low number of consultants was affecting the department's ability to provide teaching sessions for the trainees, including the ultrasound training. It was stated that the department would benefit from an increased number of substantive consultants to form a faculty to better provide teaching. This was evident as the trainees stated they had not received any ultrasound teaching. The visit team found that there was a disconnect between the consultants and trainees in regards to teaching offered within the department. The college tutor stated that the teaching sessions happened regularly on Thursday afternoons which was applicable to both higher emergency medicine and ACCS trainees. These were also offered to the middle-grade trust doctors to develop their skills. However, the trainees stated that teaching did not occur on Thursdays afternoons, but Thursday mornings, but this was not formal teaching, was often cancelled and if it did occur, the trainees were often called away for clinical duties. The trainees also stated that there was no formal core teaching or specific ACCS teaching. The visit team heard that there was no wireless fidelity (WIFI) available at the Ealing Hospital site. Combined with the fact that the site did not have a license for the Oxford handbooks and many e-journals it made the educational resource of the Ealing Hospital site very limited. **Northwick Park Hospital** The college tutor stated that the ACCS trainees were welcome to attend the foundation year two trainee teaching which occurred on a Friday afternoon every week, but conceded that ACCS trainees needed higher level teaching than foundation content. The ACCS trainees were also invited to the acute medicine teaching that took place on Tuesday afternoons.	Yes, see below EMACCS1.8a Yes, see below EMACCS1.8b

	The visit team heard that the teaching on Tuesday mornings for higher and middle grades doctors had been organised by a higher trainee and had been very good. Unfortunately, this trainee had left, and the trainees reported that the quality of the programmed teaching had suffered; it had become irregular and was no longer protected. This was corroborated by the college tutor and clinical lead for emergency medicine, who stated that the teaching programme needed to be reviewed and improved. The trainees stated that they would like the content of the middle-grade teaching to be curriculum centre, with a programme that allowed topics to be reviewed in advanced, case-based learning with guidelines and involved a mixture of interactive discussions, quizzes, and didactic teaching. They stated that it would also be useful to know the topics beforehand to allow them to prepare for the lesson. The trainees also stated that they wanted this time to be protected and would appreciated not being pulled out of teaching to cover the shop floor because of the lack of locums. It was reported that the teaching for ACCS trainees within anaesthetics was very good. The ACCS trainees did however state that they would appreciate a refresher on the novice anaesthetist course before they started anaesthetics as they felt it was a long time from the course at the start of their training programme to when they started anaesthetics. The trainees stated that the resources at the site were good, and the new department was very good, however there was never enough printers available in the department, or fax machines and sometimes the phones would not work.	Yes, see below EMACCS1.8c Yes, see below EMACCS1.8d
EMACCS 1.9	**Access to simulation-based training opportunities** **Ealing Hospital** The college tutor stated that there had been paediatric simulation training that had occurred regularly to ensure paediatric competencies were maintained, however this weekly paediatric simulation training had stopped for the foundation year two doctors and it was reported that there would be no paediatric simulation at all by August 2016. In combination with the lack of paediatric cases the emergency department would handle due to the closure of inpatient paediatric services in June 2016 and the lack of simulation training, the visit team found that there were minimal opportunities for trainees and staff to gain and retain paediatric competences. The college tutor at Ealing Hospital stated that they could not access the simulation opportunities at Northwick Park Hospital. **Northwick Park Hospital** The college tutor for emergency medicine stated that they were trying to incorporate simulation training into the middle-grade Tuesday morning teaching. The trainees the visit team met with did not refer to simulation opportunities. The consultants within the emergency department at Northwick Park Hospital stated that they had not maximised the simulation opportunities and although there was a designated simulation room within the new emergency department and simulation trained consultants this was not used effectively. The visit team heard that there were discussions about attracting a simulation fellow for the department. The visit team would strongly recommend the Trust invest in a simulation fellow who works across both hospital sites to improve simulation training.	Yes, see below EMACCS1.9

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.		
EMA CCS 2.1	**Effective, transparent and clearly understood educational governance systems and processes** **Ealing Hospital** The visit team was informed that anaesthetic and emergency medicine consultants were the only representatives at the local faculty group (LFG) to discuss ACCS training issues. However, the college tutors for emergency medicine and anaesthetics stated that they felt confident that the acute medicine consultant would be willing to participate in the LFG if they were invited. The college tutor stated that there was a large LFG attended by ACCS and higher EM trainees for Ealing Hospital. The trainees confirmed that there were representatives for ACCS at the LFG, but the trainees were unaware of a larger LFG which included medicine. The visit team heard that there were no plans for a trust-wide ACCS faculty meeting. It was reported that the acute medicine consultants were unaware of the ACCS curriculum requirements for trainees in acute medicine. While ACCS trainees were within acute medicine the infectious diseases consultant was responsible for training all ACCS trainees. **Northwick Park Hospital** The visit team heard that there were separate LFGs for both ACCS and emergency medicine at Northwick Park Hospital. However, trainees have not attended the LFGs, even though the clinical lead stated that the rotas were flexible and would allow trainees to attend. The trainees stated that there was very little opportunity for all trainees to attend LFGs but they felt that they could raise issues with training and education through other conduits.	Yes, see below EMACCS2.1
EMA CCS 2.2	**Impact of service design on learners** The visit team found that the hospitals within the Trust were still operating as discrete sites, with minimal collaboration. This was evident at an educational governance system level but also between the emergency departments. The visit team heard that there had been no discussions between the departments regarding joint working or intra-trust rotations to improve training opportunities. The perspective of the emergency department at Ealing Hospital was one of being dictated to by Northwick Park Hospital and that collaboration was unlikely because although Ealing Hospital would benefit, there would be little to benefit Northwick Park Hospital. Conversely, the college tutor for anaesthetics at Ealing Hospital stated that the two departments had begun to look at how the merger could propagate mutual symbiosis for service and training and education needs. The visit team was pleased to hear of the dialogue between the two college tutors in anaesthetics and would strongly encourage this practice in other specialties. The visit team heard that the closure of the inpatient paediatric services at Ealing Hospital prevented the emergency department from providing training competencies in paediatrics for higher emergency medicine trainees. The college tutor stated that the department could no longer support core training three (CT3) trainees and the training environment, at the time of the visit, could not provide paediatric cases for ACCS trainees. The college tutor for emergency medicine at Northwick Park Hospital also stated that there were no ST3 or paediatric emergency medicine training posts at Northwick Park Hospital because of the lack of a paediatric emergency medicine consultant. Although Northwick Park did have paediatric consultants with an interest in emergency medicine, and the college tutor assured the visit team that they were well staff for emergency medicine paediatric cases. The trainees conformed that there was good support from the paediatric department within the emergency department. The visit team heard that at Northwick Park Hospital there were two paediatric consultants who had a special interest in emergency medicine but the college tutor at Ealing Hospital stated there had been no discussions regarding a collaboration of the two sites. However, the college tutor for anaesthetics stated that there was a plan to	Yes, see below EMACCS2.2

	ensure the anaesthetic trainees' paediatric anaesthetic competencies by sending them to Central Middlesex Hospital. This was not for ACCS anaesthetic trainees, as this was not part of the curricular requirements. The college tutor and clinical lead for emergency medicine at Northwick Park Hospital stated that the merger had brought opportunities to configure a joint recruitment strategy for the two departments, but no discussions had taken place.	
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.**		
EMA CCS 3.1	**Behaviour that undermines professional confidence, performance or self-esteem** **Ealing Hospital** The visit team heard that on the whole the trainees had not witnessed or experienced and particularly episode of bullying and undermining. However, the visit team was informed of clashes between trainees and consultants, which had proved difficult for the trainee involved. This was also compounded by the fact that there were only two consultants within the department. **Northwick Park Hospital** The visit team heard that the workload and the intensity of the department could be very high and that this sometimes perpetuated behaviour, that although the trainees would not called bullying and undermining, was not kindly received. The four-hour quota for waiting within the emergency department meant that trainees could often be told to work faster, and could be pressurised by the nursing staff (trainees understood that this was because the nurses themselves were being pressurised from the top down). The trainees stated that it was difficult to ensure that patients were discharged or referred to a specialty within four hours because of the high volume of patients it meant that trainees would only start reviewing them after two hours. The trainees stated that they had learnt to deal with this and ensure the patients were being safe and being treated properly. The visit team was concerned to hear of bullying and undermining within the acute medicine department. This had been dealt with outside of the report.	Yes, see below EMACCS3.1
GMC Theme 4) Supporting educators		
Standards **S4.1 Educators are selected, inducted, trained and appraised to reflect their education and training responsibilities.** **S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.**		
EMA CCS 4.1	**Access to appropriately funded professional development, training and an appraisal for educators** **Ealing Hospital** The visit team heard that at Ealing Hospital in the emergency department one of the ramifications on education and training because of the lack of substantive consultants	Yes, see below EMACCS4.1

	was the lack of trained, suitable educational supervisors. This put strain on the two substantive consultants who were the only trained educational supervisor, and limited the time they could spend on their educational responsibilities. The visit team was also concerned that with only two suitable consultants, there was little choice for the trainees if they needed to, or wanted to change education supervisor. The visit team heard that the college tutor for emergency medicine at Ealing did not receive an additional special programmed activity (SPA) allocation in the job plan for the college tutor role. Educational programmed activity allowances were not allocated to consultants for educational supervision responsibilities, but the college tutor did state that one of the SPAs within the job plan could be used for meetings between trainee and trainer. The college tutor for emergency medicine also stated there was no time to attend the education meeting that occurred every Tuesday afternoon, and was unaware of the content of the meeting. The college tutor for anaesthetics stated that they attended and it was chaired by the director of medical education where training issues could be discussed. The visit team was concerned that with the lack of educational supervisors and the lack of Trust support, stipulated within the job plan, there would be little impetus for other consultants to become trained education supervisors. Conversely, the trainees did state that they had all been allocated an educational supervisor on their inception at the Trust and that they met regularly with them, even though there were only two educational supervisors. However, one of the main improvements the trainees would have liked to see was additional consultants in the emergency department because at the time of the visit they were unable to provide adequate training. The college tutor was described as being particularly accessible, supportive and approachable in regards to education supervision and advice on the higher trainee emergency medicine exam. **Northwick Park Hospital** The visit team identified a discrepancy between the two college tutors for emergency medicine within the Trust. The college tutor at Ealing Hospital had no additional PAs for the college tutor role; however, the one at Northwick Park Hospital had an additional one PA allocated. The college tutor stated that apart from the locum consultant all other consultants were both educational and clinical supervisors. However, the visit team found that there was an inequitable distribution of trainees to trainers, with the college tutor undertaking the supervision of potential 11 trainees, made up of higher emergency medicine trainees, some foundation year two trainees and all the ACCS trainees. However, another consultant supervised the GP trainees. The trainees praised the support of the college tutor and had no concerns regarding the level of educational supervision they received. However, the visit team was concerned that this inequity meant the department was missing an opportunity to develop as a faculty and ensure succession planning to sustain the high levels of educational supervision. The ACCS trainees stated that they were all under the educational supervision of the college tutor for emergency medicine but that in acute medicine it took a long time to be ascribed as clinical supervisor. The college tutor for emergency medicine stated that there was a committee to discuss trainees in difficulty and how to offer them the best pastoral support.	

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.

EMACCS 5.1	**Training posts to deliver the curriculum and assessment requirements set out in the approved curriculum** **Ealing Hospital** The visit team found that at both sites the relationship between the privately owned urgent care centres (UCC) were impeding training opportunities, especially, exposure to minor injuries, for both higher emergency medicine and ACCS trainees. The visit team heard that at Ealing Hospital trainees, in the past, had not been allowed to enter the UCC for training because there were concerns regarding the clinical governance systems, the trainees' indemnity while working within the department and contractual issues. Trainees within the emergency medicine had been training within the UCC at the time of the visit, but the college tutor stated that despite the department having a good relationship with the UCC, trainee feedback was not good. The college tutor reported that the shifts in the UCC were uninteresting, lacked learning opportunities and the trainees tended to leave the UCC to work within the emergency department. The college tutor stated that there was no scope for the UCC operating out of hours and this was detrimental to training opportunities. The visit team heard that there was no resolute plan for providing training opportunities in minor injuries outside of the UCC, except for some teaching, but this was described as sporadic, due to lack of attendance. The visit team heard that for ACCS and DRE-EM trainees the emergency department did not provided sufficient cases for minor injuries; the trainees saw no pink eye or sprained ankles. The trainees stated that they were only able to attain minors competencies through e-learning modules. Additionally, the visit team heard that even if there was an increased exposure of minors within the emergency department, the trainees would not feel comfortable going through a case based discussion (CBD) with the middle-grade trust doctors because of their competence and because there were only two substantive consultants, there would be limited opportunities to discuss these cases. The college tutor stated that for one week every seven to eight weeks the trainees were able to access the consultant led day-case surgery. This allowed trainees to be exposed to complex lacerations, and abscesses, although the college tutor did state that the case mix volume could vary between two to six cases per day. The trainees, the visit team met with did not mention the day-case surgery as a training opportunity. The trainees stated that because the middle-grade trust doctors were not considered competent the majority of work that could be undertaken by and in the emergency department was instead undertaken by the medical specialties. The trainees stated that there was a low threshold for calling the medical specialties, especially for paediatrics and the arrest calls were managed by anaesthetics, even when the patient was in the resuscitation area of the emergency department. The trainees stated that this ensured patient safety but minimised training opportunities for emergency medicine trainees because the doctors from medicine would take over the care of the patient. This also meant that the trainees did not feel confident to lead an arrest call on the medical wards either, so missed out on another training opportunity when on the acute medicine rotation. The trainees actually expressed serious difficulties attaining practical procedures, within the emergency department to ensure an outcome one at the academic review of competence progression (ARCP), particularly chest drains. The trainees stated that because the dearth of practical procedures they had not been able to advance. Others stated that if they had not undertaken locum shifts at other trusts they would not have passed their competencies because Ealing Hospital emergency department did not provide exposure to cardiac arrests, trauma or airways. The visit team heard the majority of trauma cases went to St Mary's Hospital (Imperial College Healthcare NHS Trust). It was also reported that for ACCS trainees, the emergency medicine department was very poor for placing tubes or lines. This was not deemed an issue for the ST1 trainees because they could complete all five directly observed procedures (DOPs) within medicine. The trainees also stated that because there were only two substantive consultants in	Yes, see below EMACCS5.1a

	the emergency medicine department it was not always easy to get workplace-based assessments (WPBAs) signed off. The trainees did however state that one consultant was far more proactive than the other and would discuss cases. However, the trainees stated that because of the minimal case mix there was not always enough cases to discuss. It was reported this combination of lack of cases and access to consultants meant that in the six months of a ST3 post within the emergency department there would be little chance of attaining the necessary competencies.	
	Only one of the trainees the visit team met would recommend the training environment for higher emergency medicine training. This was due to the management and leadership training you inadvertently received from having to run the department. However all other trainees stated that the lack of clinical supervision and the very poor, limited case mix prevented the attainment of an adequate number of competencies.	Yes, see below EMACCS5.1b
	The visit team was pleased to hear that for ACCS trainees it was very easy to attain the anaesthetic competencies while on the anaesthetics rotation and the consultants were supportive in identifying learning events and providing timely sign-off and feedback.	
	The college tutor stated that the additional consultants in the acute medicine department meant that there was an improved ability of the acute medicine department to accommodate ACCS trainees, especially in the acute medicine unit (AMU). However, the visit team was informed by the college tutor that the trainees preferred to undertake on call in acute medicine, and then three months in cardiology and three months in infectious diseases for their acute medicine ACCS rotation.	
	The training experience for ACCS trainees in acute medicine was described as very good. The acute medicine on call and the acute medical take provided good training opportunities. The acute medicine consultant stated that within the post-take ward rounds, held between 6:30am to 8:30am, the consultant reviewed 40 to 50 new patient admissions, which was a high workload, but that teaching opportunities were incorporated into this time. The acute medicine consultant informed the visit team that achieving sign off on an acute care assessment tool (ACAT) was quite difficult but that if asked would be able to undertake an ACAT.	
	The visit team was informed that infectious diseases had good knowledge and understanding of the ACCS curriculum and provided good training opportunities too. The only negative aspect of the acute medicine rotation at Ealing was the disorganised cardiology department, who had no understanding of the ACCS trainees' requirements and treated them as service provision. The higher trainees (or equivalent trust-grade doctors) in cardiology were described as supportive and identified training opportunities for the ACCS trainees in acute medicine; however the consultants were disengaged from the process.	Yes, see below EMACCS5.1c
	Northwick Park Hospital	
	The consultants stated that the UCC at Northwick Park Hospital was run by the Trust, but staffed with general practitioners (GPs) from a private company. The visit team heard that the UCC sat at the front end of the patient pathway and would stream and undertake initial assessments of patients and treats approximately 50 per cent of patients, with 300 patients per day being seen by the emergency department. The clinical lead stated that recently the lead GP had moved to another Trust and that the conversion rate of patients being seen in the UCC and then admitted into the emergency department had increased from six to eight per cent, which was concerning to the department and they were actively trying to decrease this figure. All the trainees the visit team met with stated that the UCC inhibited any learning or training because they were unable to participate in any way, and instead felt like a medical student again. The trainees were worried that because of this they would be inexperienced and under confident to treat minor injuries when they moved to different trusts.	
	The trainees stated that the one problem with the emergency department was that because the consultants changed daily they were unaware of what the trainees had previously done and so were normally allocated to the same areas. This uneven distribution in different areas meant that trainees felt they were missing time in the resuscitation area and paediatrics. The trainees stated that it would be good if they could be allocated set blocks of different areas within the emergency department,	Yes, see below EMACCS5.1d

	which gave them an even distribution of exposure. The college tutor for emergency medicine at Northwick Park Hospital stated that trainees could receive sign off on their WBPAs by all of the consultants within the department. Although, the trainees did state that the consultants required a considerable amount of chasing to sign the WPBAs off. The visit team was also pleased to hear that consultants proactively search out learning opportunities for the trainees in the emergency department, such as walking round with ECGs and asking trainees to assess them. The trainees did however state that it could be difficult to have other informal teaching or consultant supervision with ultrasound training because the department could be so busy. The consultants did concede that at times, they gave into service pressure and neglected to teach the trainees in certain instances because it was faster to undertake the procedure themselves. The trainees praised the addition of two months in the high dependency unit (HDU) within the ACCS acute medicine rotation at Northwick Park Hospital. It was stated that this allowed trainees to be exposed to extreme level two cases, under excellent clinical supervision with opportunities to place central line and see both acute medical and surgical patients. The ACCS trainees while in acute medicine also undertook an undifferentiated take where trainees could attain their ACATs, with instant feedback as the consultants in acute medicine understood the ACCS trainees' needs.	Yes, see below EMACCS5.1e

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
N/A			

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
	N/A		

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
EMACCS1.1a	The Trust is required to ensure that SASG doctors within the emergency department are able to provide adequate clinical supervision to all trainees, at all times, by ensuring that they meet the required RCEM standards. This is applicable to both Ealing and Northwick Park Hospitals.	The Trust is required to undertake an urgent review of the competence of all levels of SASG doctors. This should include an implementation plan to ensure that all SASG doctors meet the RCEM minimum competence standards and have up-to-date ALS and ATLS courses. The Trust is required to provide the outcome of the review including the implementation plan. This should be followed by a list of the SASG doctors and their corresponding accreditations, as a Trust SASG competency assessment document. This should then be corroborated with	R1.1 and R1.8

		LFG minutes which demonstrate trainee feedback on the level of clinical supervision trainees receive from SASG doctors.	
EMACC S1.1b	The Trust is required to ensure that paediatric resuscitation skills and paediatric airway competencies are maintained at Ealing Hospital for all walk-in paediatric resuscitation attendances.	The Trust is required to provide a plan of how paediatric resuscitation skills and paediatric airway competencies will be maintained at Ealing Hospital. Including the rotas which demonstrate that there are always staff who have paediatric resuscitation skills and paediatric airway competencies available for all walk-in paediatric resuscitation attendances.	R1.1
EMACC S1.2a	The Trust is required to clarify the reporting and feedback pathways for Datix and serious incidents to trainees at Northwick Park and Ealing Hospitals. This should include a robust system for providing trainees with feedback in an efficient, constructive, and supportive manner.	The Trust is required to provide a review of the reporting and feedback pathways for Datix and serious incidents. This should include trainee involvement to build a more supportive and constructive feedback process. The Trust is required to provide the minutes of the LFG which show trainee feedback on serious incident reporting pathways. This should demonstrate trainee feedback and responses to improve the feedback and reporting system.	R1.6
EMACC S1.2b	The Trust is required to ensure that EM and ACCS trainees can regularly attend M&M and clinical governance meetings. This is applicable to both Ealing and Northwick Park.	The Trust is required to provide the trainees' rotas which show protected time for trainees to attend M&M and clinical governance meetings. The register of the M&M and clinical governance meetings and the minutes of the LFG, which demonstrate trainees are able to attend these meetings on a regular basis.	R1.5, and R1.16
EMACC S1.3a	The Trust is required to increase the consultant presence and direct clinical supervision received by trainees within the Ealing Hospital emergency department from 8am to 10pm seven days per week. The Trust is urged to significantly increase the number of substantive whole time equivalent consultants within the emergency department at Ealing Hospital, either through recruitment or cross-site working with Northwick Park Hospital. The Trust should meet the RCEM minimum requirement of 10 EM consultants for the emergency department.	The Trust is required to provide the rotas for trainees and consultants which demonstrate direct clinical supervision on the shop floor and this should corroborate with trainee feedback confirming adequate levels of clinical supervision through LFG minutes. The Trust is required to provide the plans for increasing the consultant numbers within the emergency department at Ealing. This should include recruitment plans, cross-site working plans or other implementation plans. This should include a timescale of implementation and a contingency plan for consultant clinical supervision in the emergency department.	R1.7
EMACC S1.3b	The Trust is required provide adequate clinical supervision to ACCS trainees within the cardiology department at Ealing Hospital.	The Trust is required to provide an outcome of the review of clinical supervision available to ACCS trainees within the cardiology department. This should be corroborated with LFG minutes that demonstrate trainee feedback that they are receiving adequate clinical supervision within the cardiology department.	R1.7

EMACC S1.4	The Trust is required to ensure that the ST3 trainee position within both Ealing and Northwick Park Hospitals emergency departments is clarified and clear to all staff and that the ST3 trainee has competent higher-grade clinical supervision at all times.	The Trust is required to provide communications to all staff that clearly identify the ST3 role as a core trainee role and not a higher trainee role and LFG minutes which corroborate this and provide ST3 trainee feedback that demonstrate trainees are receiving adequate clinical supervision from a higher-grade competent clinician.	R1.8 and R1.9
EMACC S1.5a	The Trust is required to ensure there is an appropriate rota structure for the emergency department at Ealing Hospital. This should include a review of the rotas and ensure that there is also protected teaching time, adequate study and annual leave. Ideally, a three-tier rota should be implemented with discrete tiers for foundation year two, core trainees, and higher trainees/equivalent grades. HEE recognise the difficulty in recruiting SASG doctors within emergency medicine. Other solutions looking at differing models of care and reviewing the skill mix of other health professions within the emergency department to provide safe patient care is strongly suggested.	The Trust is required to provide the proposed new rotas, the implementation plan and trainee feedback through LFGs minutes.	R1.12
EMACC S1.5b	The Trust is required to provide the review of the rota structure at Northwick Park in the emergency department to a two tier structure. HEE recognise the difficulty in recruiting SASG doctors within emergency medicine. Other solutions looking at differing models of care and reviewing the skill mix of other health professions within the emergency department to provide safe patient care is strongly suggested.	The Trust is required to provide the proposed new rotas, the implementation plan and trainee feedback through LFGs minutes.	R1.12
EMACC S1.5c	The Trust is required to ensure that all ACCS trainees in acute medicine can take study leave, annual leave and compassionate leave.	The Trust is required to provide the protocols for taking study leave, annual leave and compassionate leave and corroborate this with trainee feedback through the LFG that demonstrate that trainees can effectively take all types of leave.	R1.12
EMACC S1.6	The Trust is required provide a timely Trust induction which is in line with rotation dates at Ealing Hospital.	The Trust is required to provide the dates of the revised Trust induction programme and corroborate this with trainee feedback from the LFGs that demonstrate timely and efficient Trust induction.	R1.13
EMACC S1.7	The Trust is required to implement a formal evening handover before the on duty consultant leaves the department at Northwick park Hospital.	The Trust is required to provide an outline of the evening handover, including the attendees and then corroborate this with LFG minutes which demonstrate that the handover is effective and held daily.	R1.14
EMACC S1.8a	The Trust is required to ensure that there is a robust and discrete local teaching	The Trust is required to provide the teaching programmes for both ACCS and	R1.16

	programmes for ACCS and higher EM trainees. This should be for both sites and should be mapped to the different curriculums. The teaching sessions should be held regularly and be bleep free and protected.	higher EM trainees for both Ealing and Northwick Park Hospitals this should be corroborated with an audit of attendance and LFG minutes which demonstrate trainees are able to attend the protected teaching.	
EMACC S1.8b	The Trust is required to ensure that there is WIFI access within all parts of the Trust, and at all sites, especially Ealing Hospital. The IT facilities must ensure that trainees can access the online academic resources.	The Trust is required to provide the implementation plan for WIFI across the Trust and corroborate this with trainee feedback through LFGs which demonstrate WIFI is accessible across the Trust and they can access online resources.	R1.19
EMACC S1.9	The Trust is required to provide trainees with simulation based training opportunities on both sites and this should include learning from serious incidents and paediatric resuscitation simulation opportunities.	The Trust is required to provide the simulation training programme available for both ACCS and higher EM trainees at Ealing and Northwick Park Hospitals. This should be corroborated with an audit of participation and LFG minutes which demonstrate trainees are able to attend regularly and the simulation training is appropriate and applicable to their training needs.	R1.17
EMACC S2.1	The Trust is required to ensure faculty representation from all four ACCS specialty posts at ACCS LFG at Ealing and Northwick park Hospital. It is recommended that the Trust not only have separate LFGs per site for ACCS but they also hold a joint site LFG twice a year. The LFGs should have minutes, a register, a resulting action plan. They should be attended by all consultants and trainees and management involved with education and training and should be held at least 4 times per year.	The Trust is required to provide the terms of reference for the ACCS LFGs and the minutes, action plan and registers of the LFGs for the next year from both Ealing and Northwick Park.	R2.7
EMACC S2.2	The Trust is required to provide a framework for collaborative working between the emergency medicine departments of Ealing and Northwick Park Hospital to improve the education and training environment. The Trust should look to the anaesthetics departments for good practice in this matter. HEE would like to facilitate this collaborative approach.	The Trust is required to provide the collaborative working framework, a timescale and implementation plan for improving education and training opportunities across the two sites. This should be corroborated with LFG minutes from both sites for ACCS and EM which demonstrated trainee involvement in this plan and the efficiency of the implementation of this plan.	R2.3
EMACC S3.1	The Trust is required to compile a report on the bullying and undermining behaviour with the emergency medicine department at Ealing hospital and the acute medicine department at Northwick Park. The Trust should provide a robust response to any untoward behaviour and support trainees.	The Trust is required to provide the report and any action taken by the Trust to address bullying and undermining behaviour.	R3.3
EMACC S4.1	The Trust is required to increase the number of educational supervisors on both sites to ensure that educational responsibilities are shared equally amongst trained consultants.	The Trust is required to provide a list of the number of trained education supervisors, the GMC trainer modules they have completed, the number of trainees they supervise and LFG minutes which demonstrate that consultants are	R4.1

	This should also include appropriate allocation of PAs within the job plans of education supervisors and college tutors.	allocated the correct PAs within their job plans and that trainees are receiving adequate educational supervision.	
EMACC S5.1a	The Trust is required to ensure that the UCC on both the Ealing and Northwick Park Hospital sites are adequate training environments. Trainees must be able to attain curriculum requirements within the UCC. There should also be a plan implemented to access the UCC OOHs at Ealing Hospital. This plan should also ensure that trainees are covered legally within the UCC.	The Trust is required to provide a review of the UCC and a curriculum mapping exercise of how the UCC will fulfil trainee curriculum requirements including OOHs. This should be corroborated with LFG minutes that demonstrate trainees are able to use the UCC as an adequate training environment.	R5.9
EMACC S5.1b	The Trust is required to ensure that the emergency department at Ealing Hospital allows for ACCS and higher EM trainees to attain their curriculum competencies.	The Trust is required to undertake a curriculum mapping of the emergency medicine department at Ealing hospital which maps the cases available within the department to the curriculum requirements of all trainees working within the department. If the review finds that the training environment does not adequately support training then the Trust is required to provide a plan of how this will be addressed. The Trust is then required to corroborate implementation of plans to improve the training environment with LFG minutes to demonstrate trainees are able to attain curriculum competencies.	R5.9
EMACC S5.1c	The Trust is required to review the cardiology ACCS rotation at Ealing Hospital and ensure that this is adequate for ACCS training curriculum requirements. If it is found that the cardiology placement is inadequate a new firm placement should be found.	The Trust is required to provide the outcome of the review and plans for how to improve or change the firm placement for ACCS acute medicine.	R5.9
EMACC S5.1d	The Trust is required to ensure the equitable distribution of trainees allocated to different zones in the Northwick Park emergency department to ensure that trainees can meet training curriculum requirements.	The Trust is required to provide the trainees' rotas which clearly demonstrate equitable distribution of zones to trainees over the course of their rotation and this should be corroborated with LFG minutes which demonstrate that these rotas are effectively implemented and trainees are able to have a range of exposure in different areas of the emergency department.	R5.9
EMACC S5.1e	The Trust is required to ensure that all ACCS and higher EM trainees can attain adequate sign-off on WPBAs.	The Trust is required to review the number of WPBAs trainees are able to attain sign-off on and ensure that a plan is implemented to increase this number to ensure adequate levels of sign-off. This should be corroborated with LFG minutes demonstrating trainees can attain regularly and timely sign-off on WPBAs.	R5.9

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
EMACC S1.8c	It is recommended that the Trust review the need for a refresher anaesthetic course for ACCS trainees who start their anaesthetics rotation in February at Northwick Park.	The Trust should provide plans of a fresher course for ACCS trainees starting anaesthetics in February and LFG minutes to demonstrate trainees are receiving the refresher course.	R1.16
EMACC S1.8d	It is recommended that Northwick Park emergency medicine department invest in efficient printers.	The Trust should provide an update on the procurement of the printers and this could be corroborated through LFG minutes.	R1.19

Other Actions (including actions to be taken by Health Education England)

Requirement	Responsibility
N/A	

Signed

By the Lead Visitor on behalf of the Visiting Team:	Dr Chris Lacy
Date:	23 August 2016