QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Epsom and St Helier University Hospitals NHS Trust

Geriatric Medicine and Acute Medicine

Risk-based Specialty Review

Quality Review report

Date: 07 June 2016

Final Report

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Quality Review details

Background to review	The Trust was last visited for a Trust-wide review on 10 December 2013 at which there were no actions identified within geriatric medicine specifically. However, at the time of the 7 June 2016 visit, actions remained open regarding the development of a robust tracking system for medical patients once they left the Acute Medical Unit (AMU) at St Helier Hospital as well as an action regarding the informal nature of the medical morning handover. On 21 January 2016, meetings took place between Dr Claire Shannon (Head of the London Academy of Anaesthesia), Dr Anand Mehta (Trust Liaison Dean) and Victoria Farrimond (Learning Environment Quality Coordinator) with trainees and trainers working on the AMU and Intensive Care Unit (ICU) at the St Helier Hospital site. The purpose of these meetings was to explore the training and education provided on the AMU and ICU at St Helier Hospital. Health Education England South London (HEE SL) was concerned that given the service pressures the consultant team were dealing with, they would be unable to provide sufficient educational activities and support to the trainees. The visit team concluded that staffing and workload on the AMU were detracting from a meaningful training experience. There was one mandatory requirement for the Trust resulting from this visit. This mandatory requirement specified that all trainees working on the AMU should be relieved for bleep-free mandatory training as required by their curriculum. At the time of the 7 June 2016 visit, this action remained open and was due to be reviewed at the visit. The visit team was keen to explore how far improvements had been made within the AMU in relation to the above concerns and to ascertain current trainee perception of their training experience. Additionally, availability of middle grade cover and whether trainees were completing duties within their level of competence was due to be explored. Regarding geriatric medicine, the visit team was keen to explore issues that had been highlighted in the General Medical Council National Training Survey (GMC NTS) for 2015 which included red outliers for ‘clinical supervision out-of-hours’ and ‘study leave’. Additionally, pink outliers were indicated for ‘induction’, ‘supportive environment’ and ‘access to educational resources’. Finally, the experience of geriatric medicine trainees on the AMU was to be explored at the visit.
Specialties / grades reviewed	The visit team met with trainees in the general practice vocational training scheme (GPVTS) as well as core medical trainees and higher specialty trainees at both the Epsom Hospital site and the St Helier Hospital site including: • core medical trainee year one (CT1) trainees • core medical trainee year two (CT2) trainees • specialty trainee year two (ST2) trainees • specialty trainee year three (ST3) trainees • specialty trainee year seven (ST7) trainees
Number of trainees and trainers from each specialty	The visit team met with trainees in geriatric medicine, respiratory medicine, acute medicine, acute care common stem (ACCS) as well as GPVTS trainees with experience of the AMU. Additionally, the visit team met with the following: • clinical director for medicine • clinical lead for geriatric medicine • clinical lead for acute medicine

	• college tutor for medicine • deputy chief nurse • joint medical director • educational supervisors in geriatric medicine • clinical supervisors in geriatric medicine • consultants in geriatric medicine and acute medicine
Review summary and outcomes	The visit team would like to thank the Trust for accommodating the visit and for ensuring good attendance at the sessions. The visit team met with the trainees and trainers separately at the Epsom Hospital site and the St Helier Hospital site. **Epsom Hospital site** The visit team identified an area of serious concern regarding computer login details which were not provided to locums and meant that trainees had to share their computer logins. In addition, the visit team heard that there were various areas requiring improvement including: • There were issues with the morning handover time with the day shift starting at the same time as the night shift ended, resulting in them regularly finishing late. Additionally, the consultant post-take ward rounds had variable start times depending on the consultant and could start anytime between 7am and 10am. • There was a lack of clarity around the roles and expectations of the acute response team (ART) and the interface with the critical care unit (CCU). • There were issues with information technology (IT) at the Trust. This included a lack of access to the electronic neurosurgery referral system to St George's Hospital (which could only be accessed by one computer in the ED). It was reported at weekends there was a lack of IT support. • Training days and clinics were both scheduled on a Thursday which meant that higher geriatric medicine trainees had to cancel clinics to attend training days. However, the visit team heard that medical managers sometimes reinstated these clinics without communicating with the trainees. The visit team highlighted areas that were working well as follows: • Trainees received good general medicine experience and there was a good general internal medicine (GIM) case mix for specialty trainees year 3 (ST3). There were good leadership opportunities for senior higher trainees within geriatric medicine. • There were good opportunities to complete workplace based assessments and good higher trainee support. • For core medical trainees, there were dedicated respiratory clinics which could be replicated in other specialties. **St Helier Hospital site** **Geriatric Medicine** Regarding geriatric medicine at the St Helier Hospital site, the visit team did not identify any serious concerns but did highlight the following areas for improvement: • Trainees in GPVTS did not receive clinic access, which the visit team felt they should have access to as this could be a valuable training

experience. .

- Trainee perception was that there were no trainee forums in which to feedback any concerns they may have had regarding their teaching and training.
- The visit team heard that trainees did not regularly receive feedback on Datix forms they had submitted, despite requesting this.

The visit team also identified areas that were working well as follows:

- The majority of consultants at the Trust were supportive and engaged in education and training.
- Trainees received good support for supervised learning events (SLEs) and bedside teaching.
- The trainees informed the visit team that they received good general geriatric medicine and general internal medicine (GIM) training opportunities.

Acute Medicine

The visit team identified an area of serious concern, as follows:

- There was no formal morning handover of sick patients for medicine, although there was a consultant presence in the acute medical unit (AMU). The Trust is required to instate a formal morning handover with a specified time and place.

Furthermore, the following areas were identified as areas for improvement:

- The visit team heard that the rota coordination could be disorganised and was often revised by junior trainees as changes had not been made as requested. Rota gaps had not been filled and in some cases trainees were not informed about whether they had been filled. The visit team found the consultant on-call rota was often not available to the on-call medical teams at night.
- Regarding post-take ward rounds, the on call night team was often not able to leave at the end of their shift. In some instances, trainees had been stopped from leaving work knowing that they would have to come back later that day for the next night shift. The weekend post-take ward rounds often did not start on time when they were due to commence at 8am; this was variable depending on the consultant.
- The Trust is required to review the weekend medical cover on the AMU. There is no review of all patients on AMU over the weekend although the visit team was informed that a Saturday morning AMU ward round was due to be instated.

The following were areas identified as working well by the visit team:

- Trainees noted that trainers were available and engaged with their teaching and training.
- The general practice vocational training scheme (GPVTS) trainees would recommend the Trust as a good training experience.
- The visit team was informed by the GPVTS trainees that the training they received on the AMU was good.

Quality Review Team			
Lead Visitor	Dr Catherine Bryant, Deputy Head of School of Medicine and Medical Specialties	**External Representative**	Dr Vivek Srivastava, Consultant in Acute Medicine and Education Lead (Medicine CAG), King's Health Partners
GP Representation (St Helier only)	Dr Kheelna Bavalia, Associate Dean Health Education South London	**Trainee Representative**	Dr Georgina Meredith, Trainee Representative
Lay Member	Robert Hawker, Lay Representative	**Scribe**	Kate Neilson, Learning Environment Quality Coordinator
Observer (St Helier only)	Julie Karol, Quality Intelligence Officer		

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
GM1.1	**Patient safety** The visit team heard that although there were no serious patient safety concerns reported from the trainees they met, it was noted that the majority of trainees at all levels and on both sites said that they would not recommend the Trust as a place for their family and friends to receive treatment. This was due to the fact that there was great variability in terms of the care provided between wards, largely as a result of staffing levels. These trainees raised concern around the outlier wards including the physical position of these wards as there was no connection to the main hospital so obtaining radiology and phlebotomy was more challenging.	
GM1.2	**Serious incidents and professional duty of candour** The visit team heard from the trainees at all levels that although they were encouraged to submit Datix forms, they rarely were invited to be involved in any investigation and rarely received feedback on the outcome of the subsequent investigations despite ticking the box asking for this. The higher trainees in geriatric medicine reported that there were a lot of falls on the wards which could be prevented if staffing levels of healthcare assistants were	Yes. See GM1.2 below.

	increased but they noted that the Trust was resistant to this. Datix reports had been submitted for these falls with minimal feedback received. However, it was noted that serious incidents were discussed at the Falls Steering Group and there was trainee representation on this group. The visit also heard from the deputy chief nurse that there had been a lot of work done to reduce falls at the Trust and this was closely scrutinised. The Trust had a robust system for reducing the risk of harm from falls. Overall, there was a reduction in the number of falls within the Trust and the number of injurious falls had also reduced. There was trend to a reduced number of falls in the Trust and there had been a reduction in the number of injurious falls. This had been achieved with a reduction in the use of specials providing 1:1 supervision to patients.	
GM1.3	**Appropriate level of clinical supervision** The visit team heard from trainees at all levels across both sites that clinical supervision was good and that consultants were supportive. Higher trainee support for core medical trainees and GPVTS trainees was also reported to be good. Regarding the out-of-hours rota at the St Helier Hospital site, trainees reported that there were times when there was confusion around who the on-call consultant was. Furthermore, there were instances when the Trust's switchboard did not have an updated on-call rota so were also unaware of who the on-call consultant was. The visit team was informed by trainees at the St Helier Hospital site that there were instances when consultants within the general internal medicine had not been available to do the post-take ward rounds so this fell to the acute medicine on-call consultant, who was not onsite. Datix reports had been submitted for these cases but no feedback had been received.	Yes. See GM1.3 below.
GM1.4	**Responsibilities for patient care appropriate for stage of education and training** **Epsom Hospital site** The visit team heard from the higher trainees in geriatric medicine that the job was very autonomous, especially on the wards, and that they enjoyed this aspect of the role. However, it was noted that more junior higher trainees may find this environment challenging. There was a consultant ward round on a Monday and Thursday with all patients being seen at least once a week. The wards were managed by the higher trainee and were well staffed in terms of junior trainees, when these staff were not on annual leave or study leave. However, until recently at the time of the visit, there had been a second higher post so they were understaffed in this respect. The college tutor in geriatric medicine confirmed that the department was trying to recruit a second higher trainee. The higher trainees confirmed that they covered three wards which included 59 beds plus some outliers (plus covering the stroke post-take) and this was manageable most of the time due to the fact that there were a lot of medically fit patients so the turnover was relatively low. It was noted that there was more time in order to teach the junior trainees in this environment than others. However, the higher trainees noted that the workload could be high at times and that they often had to work on 'off days' and zero days to have time to attend clinics/skills that they would otherwise miss or because of ward work requiring the trainee to be there. The higher trainees noted that the Trust was a good place for ST3 trainees to learn general medicine. However, there were limited opportunities for higher trainees between ST3 and ST7.	
GM1.5	**Rotas** **Epsom Hospital site** The visit team heard from the core medical trainees in geriatric medicine that there were no fixed clinics for them to attend so their clinic experience was limited.	Yes. See GM1.5a

	Furthermore, the higher trainees in geriatric medicine advised the visit team that clinics were not rostered into the rota but that they could attend clinics if requested. However, the geriatric medicine clinic took place on Thursday afternoons which sometimes coincided with training days as well as 'off days' prior to weekend night shifts. As a result, either training days or clinics had to be cancelled this meant that these trainees had missed training days. There were reports of clinics being cancelled with adequate notice but then being reinstated by medical managers without informing the trainees. This meant that patients attended clinics at times where there were no trainees present. Furthermore, higher trainees were only allowed to see follow-up patients and not new patients and would see ten patients with 15 minute slots each, which did not provide sufficient time. The consultant would also see ten patients at this clinic.	below. Yes. See GM1.5b below.
	The visit team heard from trainees at all levels that there were considerable rota gaps but that the core medical trainees were not as affected as the higher trainees and that consultants 'acted down' at times.	
	The visit team heard from trainees at all levels that the way the rota was designed meant that there was no overlap between the day and night shifts, with both commencing and finishing at 9am. Furthermore, although the handover was scheduled to take place at 8.30am on weekdays or 9am at weekends, this rarely happened in practice. The time of the post-take ward round was variable (between 7am and 10am depending on consultant preference) so trainees regularly finished late.	Yes. See GM1.5c below.
	The visit team heard from the core medical trainees that they would recommend the Trust as a good place to train, although it was noted that some departments were better than others. The respiratory medicine training was cited as being especially good as core medical trainees had fixed clinics in their timetable.. The visit team highlighted this as good practice and recommended that dedicated core medical trainee clinics be replicated in other specialties.	
	St Helier Hospital site The visit team was informed by the trainees in GPVTS that they did not receive clinic access, which the visit team felt they should have access to as this would be a valuable training experience.	
	Acute Medicine The trainees in acute medicine advised the visit team that the rota coordination could be disorganised and was often revised by junior trainees as changes had not been made as requested. Rota gaps had not been filled and in some cases trainees were not informed about whether they had been filled. Additionally, the consultant on-call rota was often not available to the on call medical teams at night.	Yes. See GM1.5d below.
	Regarding the post-take ward rounds, the on call night team was often not able to leave on time; during the week trainees usually left at 9.30am but this could vary at weekends and sometimes trainees did not leave until 11am (when due to finish at 9.30am). In some instances, trainees had been stopped from leaving work knowing that they would have to come back later that day for their next night shift. Additionally, the weekend post-take ward rounds often did not start on time when they were due to commence at 8am; this was variable depending on the consultant. The visit team was informed that a Saturday morning AMU ward round was due to be instated.	
	The visit team heard from the trainees that there was confusion around the ambulatory care service and whose responsibility this was. The on call team provided cover until 2pm but it was often unclear who provided senior cover during this time. Referrals went through the higher trainee within the emergency department (ED). This service did not have any junior trainees so it was covered by medical trainees from other specialties. There were usually complex cases where it is unclear whose responsibility they were which meant that they got 'bounced around' departments.	Yes. See GM1.5e below.

GM1.6	**Induction** The trainees based at the St Helier Hospital site reported that they had received a Trust and departmental induction. It was noted that the geriatric medicine induction was very good and that the stroke induction was more robust than other local inductions. The visit team heard from the trainees that the ambulatory care service was not covered adequately within the induction. Regarding the medical directorate induction, the trainees reported that this was a bit disorganised. The visit team heard that some trainees also received a personalised induction on the AMU by Dr Shah which was highly rated.	
GM1.7	**Handover** **Epsom Hospital site** The visit team heard that the core medical trainees at the Epsom Hospital site completed placements in respiratory medicine and geriatric medicine for six months each and that their experience of the AMU was limited to when they were on call. The weekend on-call jobs list was generated from the Friday afternoon handover meeting which each medical specialty attended. The discharge consultant would also highlight patients to be reviewed. A subsequent 9am morning handover took place on AMU both Saturday and Sunday which the trainees on call attended. There was no designated Acute Response Team (ART) consistently involved in the management of patients on the AMU. The patients in the AMU were not reviewed medically unless they were on the ward higher trainees' list for review for clinical reasons or on the discharge higher trainees' list. The visit team heard from the higher trainees that there was a lack of clarity around the roles and expectations of the acute response team (ART) and its interface with the intensive care unit (ICU). Following the Care Quality Commission (CQC) inspection in 2015, an ART system had been introduced but this cover was provided by a middle-grade medical trainee and senior nurse (and trainees reported these shifts were not always filled). The trainees advised the visit team that it would be helpful to have a critical care nurse to support them rather than another higher trainee. The core medical trainees advised the visit team that they were alerted via the bleep system regarding sick patients but this could be variable between wards. However, some wards were good at alerting trainees, especially the respiratory ward. These trainees noted that it was easy to get sick patients seen and referred to the intensive care unit (ICU) and that higher trainee support was good, however the system of requiring consultant to consultant referrals to the ITU could mean that there were delays when consultants were offsite. **St Helier Hospital site** The visit team heard from the trainees based at the St Helier Hospital site that referrals to the ICU had become easier as they no longer had to be a consultant to consultant referral. However, there was confusion around the current policy at the time of the visit, as the consultants and trainees reported differing views about ICU referrals. **Acute Medicine** The visit team was informed by the trainees in acute medicine that there was no formal morning handover of sick patients for medicine. This was especially concerning to them for patients on medical wards, less so for the AMU as there was consultant presence in the AMU every weekday morning. Trainees were not aware of incidents regarding patient safety due to this. Within the AMU at weekends, the visit team was informed by the trainees that there was no medical review of all patients. However, patients with clinical concerns were added to the electronic handover list but that this system meant that opportunities to discharge	Yes. See GM1.7a below. Yes. See GM1.7b below. Yes. See GM1.7c below.

	patients were missed. Although, there was a higher trainee for discharge, patients eligible for discharge were not always identified especially if they were admitted over the weekend.	
GM1.8	**Protected time for learning and organised educational sessions** **Epsom Hospital site** The core medical trainees in geriatric medicine based at the Epsom Hospital site advised the visit team that they are able to attend teaching sessions and that they should be able to achieve the 100 hours of teaching required by the curriculum. **St Helier Hospital site** The visit team was informed by the trainees based at the St Helier Hospital site that the geriatric medicine Friday morning teaching could be improved by having a more formal programme, as it was junior-led at the time of the visit. The trainees also noted that the consultants were good at delivering bedside teaching and during ward rounds. Grand rounds took place on Thursdays and core medical trainee teaching on Wednesday at 8.30am. GPVTS teaching took place on a Thursday afternoon and trainees reported that they were able to attend but often not for the full session as they found it difficult to hand over their outstanding tasks and bleep to a colleague who was already busy.	Yes. See GM1.8 below.
GM1.9	**Adequate time and resources to complete assessments required by the curriculum** The visit team heard from all trainees that they were able to complete workplace-based (WPB) assessments and that their educational supervisors were willing to do these. However the core medical trainees reported that completing acute care assessment tool (ACAT) assessments post-take was more challenging. These trainees advised that they would stay late in order to complete ACATs or go to the AMU and some were discussion based.	

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.

GM2.1	**Effective, transparent and clearly understood educational governance systems and processes** The visit team heard from trainees based at the St Helier Hospital site that there was a clinical governance meeting once a month as well as a serious incidents governance meetings which had trainee representation. However, feedback on Datix submissions was not reviewed at these meetings.	

GM2.2	**Appropriate system for raising concerns about education and training within the organisation** The visit team heard that trainees could feedback concerns around their education and training through local faculty groups as two trainee representatives attended these meetings. However, trainee perception was that there were no trainee forums in which to feedback any concerns they may have had regarding their teaching and training, especially at the Epsom Hospital site. Trainees noted that they would know how to escalate issues and would contact the consultants in the first instance.	Yes. See GM2.2 below.
GM2.3	**Systems and processes to identify, support and manage learners when there are concerns** The clinical and educational supervisors informed the visit team that there were faculty meetings in general medicine at least every quarter and regular faculty meetings with the foundation school and that they would raise any concerns they had with trainees in these forums. Additionally, they could raise issues during regular meetings with trainees and through mid-term assessments.	
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.**		
GM3.1	**Access to resources to support learners' health and wellbeing, and to educational and pastoral support** The visit team heard from the trainees that the library at the Epsom Hospital site was good, including the online resources within the library. However, remote access to these online resources was difficult and trainees were not able to access their Trust email accounts when offsite. Furthermore, the trainees informed the visit team that there were issues with the IT resources at the Trust including a lack of access to the neurosurgical referral system to St George's Hospital, with the exception of one computer in the emergency department (ED). The trainees noted that they had submitted Datix forms regarding this but had not had any feedback on these. Furthermore the trainees advised the visit team that there was no IT support out of hours and that computer logins were not provided to locum so trainees reported that they shared their logins which was against the Information Governance Policy.	Yes. See GM3.1 below.
GM3.2	**Access to study leave** The trainees at all levels across both sites reported that they were able to obtain study leave although this sometimes had to be agreed locally instead of through the rota coordinator.	
GM3.3	**Regular, constructive and meaningful feedback** Trainees in the AMU worked on different teams each day, not knowing which part of the Acute Medical Unit service they would be working in until they turned up on the unit. There was also lack of continuity of care, both with the consultants and with patients they may have seen previously. An important and useful opportunity of learning and feedback was lost as a result of this system of working. The trainees in acute medicine advised the visit team that certain consultants were more open to	

	feedback and assessments than others and that it was easier to get feedback from on calls rather than when they were on the wards. It was noted that some consultants were keen to provide feedback and teaching during ward rounds.	

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.

GM4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The visit team heard from the clinical supervisors that the majority of them received at least 0.25 programmed activities (PA) for educational duties within their job plans. Most of the clinical and educational supervisors felt valued by the Trust as educators and that there were clear and open lines of communication, advice and support available. However, others were not sure whether the Trust valued their role within education and training.	

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.

GM5.1	**Regular, useful meetings with clinical and educational supervisors** The visit team heard that all trainees had a designated clinical supervisor and that they had all met with them. It was noted that access to clinical supervisors was slightly more difficult than that of educational supervisors. Meetings with clinical supervisors were often arranged at the last minute. The trainees who had had experience within respiratory medicine noted that access to clinical supervisors varied in the department as some were more available than others. The visit team heard that all trainees had a designated educational supervisor for the whole year, who they met when required.	

Good Practice and Requirements

Good Practice	Contact	Brief for Sharing	Date
The visit team heard that core medical trainees received dedicated respiratory clinics which could be replicated in other specialties.	College Tutor	Please complete the attached pro forma and return to the Quality and Regulation Team at Health Education England (London and the South East).	10 August 2016

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
GM1.7c	The Trust is required to revise the rotas to instate a formal medical morning handover at the St Helier site with a specified time and place.	Immediate plans need to be implemented, including a specified time and place, for a morning handover.	R1.12/ R1.14
GM3.1	The Trust must ensure that all locums are provided with their own computer login details.	The Trust is to ensure that all locums have access to relevant Trust systems as per the information governance policy.	R1.13

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
GM1.2	The Trust is required to review and strengthen the serious incident process. Trust to ensure that all trainees who submit Datix reports receive feedback, including details of how the issue has been dealt with.	Trust to provide summary of feedback to trainees versus a log of Datix forms submitted by trainees. Trust to ensure that serious incident reporting is added as a standing item to the LFG meetings agenda. Trust to submit copies of LFG meeting minutes where serious incident reporting is discussed and a register of attendance for these meetings.	R1.3
GM1.3	Trust to ensure that the switchboard has an up to date out-of-hours rota that indicates which consultant is on call, including their contact details.	Trust to submit copies of the out-of-hours rota with evidence that this has been circulated to the switchboard.	R1.12
GM1.5a	The Trust is required to revise the rotas to ensure that core medical trainees in geriatric medicine and GPVTS trainees attend regular clinics. The dedicated core medical trainee respiratory clinics could be used a model.	Trust to submit copies of the revised rotas for core medical trainees in geriatric medicine and GPVTS trainees, which clearly indicates access to clinic lists. Compliance with this action should be monitored through LFG meetings.	R1.12
GM1.5b	The Trust is required to revise the rotas to ensure that the higher trainees in geriatric medicine are able to attend clinics and training days without having to regularly	Trust to submit copies of the revised rotas for higher trainees in geriatric medicine, which clearly indicates access to clinic lists.	R1.12

	cancel these.	Compliance with this action should be monitored through LFG meetings.	
GM1.5c	The Trust must ensure that the consultant post-take ward rounds commence at a consistent time in order to allow trainees to finish their shifts on time.	Trust to submit copies of communications sent to consultants advising them that they must commence ward rounds at a fixed time so that trainees are able to finish their shift on time. Compliance with this action should be monitored through LFG meetings.	R1.12
GM1.5e	The Trust must ensure that the cover arrangements for the ambulatory care service are understood by all staff working in the department and clear communications relating to this should be sent regularly to wards and all trainees. This should also be included within the local induction.	Trust to submit copies of the communications sent regarding the cover arrangements for the ambulatory care service. These arrangements should also be covered in the local induction. Compliance with this action should be monitored through LFG meetings.	R1.13 / R2.11
GM1.7a	The Trust is required to clarify with trainees the roles and expectations of the acute response team (ART) and the interface with the critical care unit. This should also be included within the local induction.	Trust to submit copies of the communications sent to trainees clarifying the roles and expectations of the acute response team (ART) and the interface with the critical care unit. Compliance with this action should be monitored through LFG meetings.	R1.12 / R1.13 / R1.14
GM1.7b	The Trust is required to ensure that the current policy regarding referrals into the ICU is circulated to staff and trainees.	Trust to submit copies of the communications sent to trainees and consultants regarding the policy around referrals into the ICU and whether these are still consultant to consultant.	R1.1 / R1.14
GM1.8	The Trust is required to formalise the geriatric medicine Friday morning teaching and ensure that there is regular, structured consultant input.	Trust to submit copies of the revised geriatric medicine Friday morning teaching programme and evidence that it has been circulated to trainees and consultants. Compliance with this action should be monitored through LFG meetings.	R1.16
GM2.2	The Trust must ensure that LFG meetings include trainee representation and that trainees are aware of when these meetings take place and how they can provide feedback to the trainee representatives.	Trust to submit copies of communications sent to trainees informing them of the dates for upcoming LFG meetings, who the trainee representatives are and how they can provide feedback prior to the meetings. This should also be covered within the trainees' departmental induction. Compliance with this action should be monitored through LFG meetings.	R2.7

Recommendations

Req. Ref No.	Recommendation	Recommended Actions / Evidence	GMC Req. No.
GM1.5d	Possible recommendation for designing more robust rotas in the AMU that allow for continuity of care of patients and consultant based teams	Trust to review rotas in the AMU that allow for continuity of care of patients and consultant based teams.	R1.12

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 Catherine Bryant, Deputy Head of School of Medicine and Medical Specialties
Date:	27 July 2016