Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	1st May 2019	**Level(s)**	ST
Type of visit	Programme	**Hospital**	All sites within the board area that host Geriatric Trainees.
Specialty(s)	Geriatric Medicine	**Board**	NHS Grampian and NHS Tayside

Visit panel	
Dr Stephen Glen	Visit Chair – Associate Postgraduate Dean for Quality
Dr Reem Al-Soufi	Associate Post Graduate Dean for Quality
Penelope MacGregor	Lay Representative
Chris McDermott	Trainee Associate
Alex McCulloch	Quality Improvement Manager
In attendance	
Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Stephen Glen Dr Reem Al-Soufi Dr Alan McKenzie
Quality Improvement Manager(s)	Alex McCulloch and Heather Stronach

Unit/Site Information		
Non-medical staff in attendance	N/A	
Trainers in attendance	North – 1 (Training Programme Director)	East – 7
Trainees in attendance	North – 3 (one trainee had to leave after 20mins)	East - 5

Feedback session: Managers in attendance	3 – Associate DME, TPD and Medical Education Manager.

Date report approved by Lead Visitor	Dr Stephen Glen 29th May 2019.

1. Principal issues arising from pre-visit review

The Deanery's scheduled visit programme aims to visit each unit/location delivering training once every five years. Accordingly, a scheduled visit was arranged to the Geriatric Medicine programmes in the North and East of Scotland.

2. Introduction

Geriatric Medicine is one of the largest specialties in the UK. It requires a generalist approach while also developing a subspecialty interest. This can range from stroke to Parkinson's Disease, falls and fracture prevention, diabetes or cardiovascular disease. It also offers the chance to work both in community and hospital settings. Research is generating an ever-expanding evidence base for the management of many conditions in old age and the National Service Framework for Older People has laid out some challenging targets for health care provision.

3.1 Induction (R1.13)

North Trainers: The Training Programme Director (TPD), advised that a local Geriatric Medicine induction is provided for trainees which follows the General Internal Medicine induction. The induction consisted of an introduction to the Immediate Assessment Unit, the stages of and expectations for training, educational supervision requirements, teaching and research. All trainees in the programme are invited, even if they are not newly appointed trainees.

East Trainers: Trainers described separate local Geriatric Medicine inductions that took place locally after site induction to General Internal Medicine. At the Royal Victoria Hospital, Geriatric Medicine induction included who the local contacts were, a half day introduction to staff and the wards (including practical arrangements) and Dr Hanslip would meet with each new trainee to discuss their training requirements. Ninewells induction consisted of provision of an induction pack and an overview of how the department runs. The TPD would arrange 1 to 1 meetings with new trainees and similar arrangements were in place at the other smaller peripheral sites in the region.

North Trainees: Trainees present confirmed they had received a formalised Geriatric Medicine programme induction. This was supported by a trainee handbook, which had been created and distributed this year to trainees and the TPD would meet formally with each trainee new to the programme.

East Trainees: Trainees experience of programme induction varied, some had meetings with the TPD early in their post and others were 3 or 4 months into their programme before they met with them. Programme induction was informal, and trainees noted the absence of an induction handbook which, inclusive of an incorporated contact list, would be an improvement that trainees recommended for the programme induction.

3.2 Formal Teaching (R1.12, 1.16, 1.20)

North Trainers: The TPD confirmed that regional teaching comprised of monthly teaching sessions that were mapped to the curriculum. Departmental Geriatric sessions were provided weekly on a Tuesday. M&M meetings took place once per month on a Tuesday. Specific weekly Quality Improvement meetings took place every Friday. In the North programme, General Internal Medicine and Geriatric Medicine sessions were interruption free.

East Trainers: Trainers advised that formal regional teaching comprised of a shared programme with the South East region, trainees had designed the programme and would organise it themselves. Local departmental Geriatric Medicine teaching included:

Ninewells Hospital: Monday departmental/unit meeting, morbidity and mortality meetings (M&M).

Royal Victoria Hospital: Tuesday lunchtime unit meeting, clinical governance meetings and M&M.

Perth Royal Infirmary: M&M and clinical governance meetings.

Geriatric Medicine departmental teaching was highlighted as interruption/bleep free.

North Trainees: Trainees confirmed regional teaching took place monthly and consisted of 2-hour sessions, trainees would organise the teaching and tried to align it to their curriculum requirements. Trainees highlighted that although it was not interruption/bleep free, they attended around 70% of the sessions provided. Departmental teaching consisted of weekly sessions on Tuesday's, weekly QI meetings and monthly M&M. The trainees highlighted the multi-disciplinary podcasts that were around broad topics such as delirium as excellent. Trainees thought joining their regional teaching programme with that of the East and South East region would be beneficial.

East Trainees: Trainees organised the regional teaching programme along with their colleagues in the South East region of Scotland. In addition to the regional teaching, local departmental teaching was provided on a weekly basis at the various sites within the region. Trainees estimated they were able to attend around 70% of the available regional teaching sessions.

3.3 Study Leave (R3.12)

North and East Trainers: The trainers did not feel there where any issues with trainee access to study leave, although it was acknowledged that trainees' commitments to the GIM rota could affect their ability to take study leave.

North and East Trainees: No issues were reported with trainee access to study leave, although trainees highlighted that GIM commitments could sometimes affect their ability to take study leave.

3.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

North Trainers: The TPD confirmed there were 2 Educational Supervisors in the North programme who would have initial 1 to 1 meetings with their allocated trainees, formally at the beginning of their programme and then regular meetings with them throughout the training year. Trainees who have known concerns are discussed regularly at the Specialty Training Committee meetings and issues are flagged early with plans put in place to support trainees in this situation. The TPD advised that trainees are discussed at the senior staff meeting, which takes place at least once per month rotating between the different grades or trainee from FYs/CMT/GPST/STs, this allowed the group to share any concerns and offer support. Trainers confirmed they received annual appraisals and appropriate training to conduct their educational roles.

East Trainers: The TPD would allocate Educational Supervisors to the new trainees in the programme each year before they started their post and supervisors would maintain responsibility for the same cohort of trainees each year to maintain continuity and knowledge of the curriculum. Trainees who have known concerns are discussed regularly at the Specialty Training Committee meetings and issues are flagged early with plans put in place to support trainees in this situation and if need be, additional support could be sought from the local Associate Post Graduate Dean for Medicine. As with the North region, the trainers confirmed they received annual appraisals and appropriate training to conduct their educational roles.

North and East Trainees: Most trainees worked alongside their Educational Supervisor, had met with them regularly informally. Formal meetings with them would take place 2 or 3 times per year.

3.5 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

North Trainers: Trainers are made aware of curriculum requirements through the TPD, who would inform them of any changes or updates. Clinic opportunities were planned into the trainee's rotas. Curriculum competences in continence were highlighted as sometimes difficult for trainees to obtain. Changes to the curriculum etc were discussed regularly at the Specialty Training Committee.

East Trainers: As with the North region, trainers advised that they are made aware of curriculum requirements and or changes to the curriculum by their TPD. Clinics access was organised for trainees and the trainers tried to accommodate what the trainee's clinic requirements were.

North and East Trainees: Small site flexibility to gain experience was highlighted as excellent by trainees in both programmes. Clinic access, in particular in relation to general Geriatric Medicine, was limited and competences that were difficult for trainees to achieve included continence in the North and tissue viability in the East.

3.6. Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

North and East Trainers: Trainers were unaware of any trainee difficulties in obtaining work-place based assessments.

North and East Trainees: Trainees generally felt it easy to get sign off for Workplace Based Assessments, except for some of the community placements, where some assessments such as Multi-Source Feedback (MSF) were difficult to obtain. This was due to the small numbers of consultants based in these sites. The orthogeriatric service was also highlighted as difficult to get workplace-based assessments as there was no consultant supervisor available to sign them off and trainees highlighted 2 Clinical Fellows as the most senior doctors working in the service.

3.7. Adequate Experience (multi-professional learning) (R1.17)

North Trainers: The TPD highlighted Quality Improvement Meetings and multi-disciplinary meetings as forums for multi-disciplinary learning.

East Trainers: Trainers highlighted educational meetings and teaching sessions as multi-disciplinary learning opportunities with Nursing staff and Allied Health Professionals contributing to and participating in the trainees teaching.

North Trainees: Trainees highlighted daily ward rounds and going out to meetings at local GP practices to discuss patients with other members of the multi-disciplinary team as opportunities for MDT learning.

East Trainees: Trainees highlighted regular MDT meetings took place in their units.

3.8. Adequate Experience (quality improvement) (R1.22)

North Trainers: The TPD described a weekly Quality Improvement meeting that took place at which discussions around current and proposed projects were discussed. Trainees were encouraged to become involved in current projects or to start their own projects.

East Trainers: Trainers confirmed there were always ongoing audit projects that trainees would have the opportunity to become involved in. Limitations highlighted were the trainees on-call commitments to General Internal Medicine.

North and East Trainees: Trainees described good opportunities to become involved in audit and in the North programme they highlighted the Friday Quality Improvement meetings as a forum where they were supported and encouraged to become involved in projects.

3.9. Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

North Trainers: The TPD felt there was a good awareness in the programme of trainees who may be requiring extra support. During the day, trainees should always have access to clinical supervision and were supported in the out-of-hours period by an on-call Geriatric Medicine consultant. The TPD advised trainees were also able to call or e-mail him directly about any concerns they may have.

East Trainers: Trainers confirmed they were able to adapt and tailor training to what trainees required and maintained responsibility for the same grade/cohort of trainees each year to maintain consistency and familiarity with the curriculum. Trainees were able to seek the support of the clinical supervisor during the day and there was no out of hours Geriatric Medicine service provided in the East region.

North and East Trainees: In Geriatric Medicine, trainees highlighted their consultant colleagues as supportive and approachable and did not report instances of having to cope with problems beyond their competence or experience. Some concerns were raised by trainees in the East region in relation to their experience of working in General Internal Medicine, one incident of a trainee contacting an on-call consultant three times for support and not receiving an adequate response was highlighted, as was the support provided for conducting certain procedures, such as central line and pleural procedures. Trainees felt there was little provision for support provided to them when carrying out these procedures which are not required in the curriculum for geriatric medicine specialist trainees.

3.10. Feedback to trainees (R1.15, 3.13)

North and East Trainers: Trainers confirmed that feedback was available to trainees informally and on regular basis, most directly through ward rounds and working with them as supervisors on a daily basis. Trainers present had attended courses on how to deliver feedback and would formalise feedback with Case Based Discussions (CBDs) for example.

North and East Trainees: Trainees felt they received informal feedback from trainers on a regular basis, although it was not always obvious to them when they were receiving it. Feedback was provided less often in the out of hours period.

3.11. Feedback from trainees (R1.5, 2.3)

North and East Trainers: Trainers advised that trainee feedback on their learning was gathered through the National Training Survey and the Scottish Training Survey which were discussed regularly at the Specialty Training Committee. Trainee representatives were members of the committee and would bring any concerns the trainees had for discussion.

North Trainees: Trainees felt they had opportunities to feedback on their training and did not raise any concerns in relation to this.

East Trainees: Trainees general felt they had opportunities to feedback on their training. However, concern was raised in relation to feedback and support being offered in a community hospital (Whitehills). A trainee felt isolated and unsupported in this placement and had fed this back to their supervisor and to the Specialty Training Committee. The trainee perceived the feedback was not well received or acted upon. There were two wards in the hospital, one of which was a Mental Health ward and the trainee described having to provide ward cover for the Medicine and Mental Health wards, the educational value of which was unclear. Feedback around trainee concerns in relation to consultant supervision in the orthogeriatric service was provided to the Specialty Training Committee but trainees were unaware if any action had been taken in relation to resolving the issue yet.

3.12. Workload/ Rota (1.7, 1.12, 2.19)

North and East Trainers: No issues were reported by trainers in relation to workload or rotas.

Trainees: Trainees had no concern regarding their Geriatric Medicine rotas or workload.

3.13. Handover (R1.14)

North Trainers: The TPD confirmed that handover took place 3 times per day, with a nursing huddle in the morning in the assessment ward which included discussion around any patients admitted overnight, an early evening (7.00pm) discussion around new admissions where preparation for which patients should be handed over to the hospital at night team. The hospital at night handover would then occur for half an hour at 9pm daily.

East Trainers: Trainers confirmed handover would take place 3 times daily in the main sites in the programme at 8.00am in the morning (Hospital at Night team to the day team), 4.30 or 5.00pm which was trainee to trainee and handover to the Hospital at Night Team at 8.00 pm.

North and East Trainees: Trainees confirmed handover to be effective and robust. It was conducted through 2 face to face meetings which took place 2 or 3 times per day and documented through e-mails and notes.

3.14. Educational Resources (R1.19)

North and East Trainers: Not covered.

North and East Trainees: Trainees confirmed adequate facilities and resources were available to them to support their learning. There were rooms available for trainees to use in all sites.

3.15 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

North Trainers: The TPD felt he was approachable to the trainees and encouraged them to contact him regarding any concerns they may have, they could do this either directly or through the Specialty Training Committee. When it was required, support could be sought out from the Scottish Deanery Performance Support Unit to help trainees in difficulty. Career support was provided in the form of promoting the sub-specialty interests to trainees.

East Trainers: Trainers advised that trainees could raise any concerns they had as a group through the Specialty Training Committee. They described the local deanery office in Ninewells Hospital as very supportive and felt they reacted to concerns quickly to support trainees**.** Career support was provided in the form of tailoring the training the trainees got to support them in their career path.

North and East Trainees: Trainees felt support was available to them, should they require it. Some of the trainees' present worked less than full-time and highlighted an issue in NHS Tayside, where trainees were granted less than full-time status in Geriatric Medicine but not for General Internal Medicine, where they were expected to work full-time out of hours. Trainees who had returned from maternity leave felt supported on their return to work and trainees in general felt support would be available to them, should they be struggling with their job.

3.16 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

North and East Trainers: Trainers in both regions had a good awareness of how the quality of education and training was managed in their programmes and sites and highlighted the local Directors of Medical Education and Associate Directors of Medical Education as being responsible for it. Trainers felt involved in quality processes and regularly discussed concerns and issue around it at their Specialty Training Committees.

North and East Trainees: Trainees in both regions had a good awareness of how the quality of education in their training was managed and confirmed the local Directors and Associate Directors of Medical Education as being responsible for it. Trainee representatives were present on both Specialty Training Committees (STC). They reported a single meeting of the North STC taking place in the last year whereas the East STC had met 3 times.

3.17 Raising concerns (R1.1, 2.7)

North and East Trainers: Trainees were encouraged to raise any concerns around patient safety, either with their supervising consultant or through Datix for more formal concerns. Feedback and learning from Datix incidents were discussed at M&M meetings. Trainees were supported and encouraged to raise and concerns around their own education and training through the Specialty Training Committees and the local Junior Doctor Forums.

North and East Trainees: Datix was confirmed by trainees to be the formal method of raising concerns. Trainees present who had been involved in incidents had received feedback. They would feedback any concerns they had regarding their own training either through the National Training Survey or Scottish Trainee Survey.

3.18 Patient safety (R1.2)

North Trainers: The TPD felt the environment they worked in was generally safe for trainees and for patients. However, the winter period was highlighted as very busy and difficult to manage in the North region, with a high proportion of medical patients being boarded out to other wards including geriatric medicine wards. A ward also had to be closed due to staffing issues with resulting pressure on the remaining bed complement.

East Trainers: Trainers in the East region felt the winter planning had improved at Ninewells Hospital with the opening of an Acute Medicine for the Elderly ward. The Royal Victoria Hospital also opened beds and worked together with Ninewells to accommodate patients that would normally require boarding in other wards.

North and East Trainees: Trainees confirmed they would not have any concerns if a relative or a friend were admitted to any of the units they worked in. They did not feel that boarded patients received the same level of care as the patients in the Geriatric Medicine wards and the number of and care of boarded patients was thought to be variable across the sites. The winter period in the North region was highlighted as difficult with high numbers of patients and understaffed departments reported.

3.19 Adverse incidents (R1.3)

North Trainers: The TPD highlighted Datix as the formal reporting tool for adverse incidents. Feedback was provided to trainees who made Datix submissions and learning from incidents discussed at M&M meetings, which included other specialties along with Geriatric Medicine.

East Trainers: Trainers confirmed Datix as the main reporting tool for formal adverse incidents. Learning from adverse events were discussed at Local Adverse Events Reviews or LAER meetings.

North Trainees: Datix was highlighted as the reporting tool for adverse incidents. Trainees felt feedback regarding Datix incidents was variable and trainees did not always receive direct feedback, although learning from the incidents were generally discussed at M&M meetings.

East Trainees: Trainees confirmed Datix as the main reporting tool for adverse incidents. Feedback was generally provided to trainees involved and learning from the incidents discussed at LAER meetings and M&M meetings.

3.20 Duty of candour (R1.4)

North and East Trainers: Trainers felt they led by example and would share their own experiences with trainees of being open and honest with patients. They would support the trainees in explaining to patients and their families what had happened when something had gone wrong whilst also providing an apology. Trainers felt reflection was important for trainees to learn from incidents and this could often be done through a reflective Case Based Discussion (CBD).

North and East Trainees: Trainees had a good awareness of Duty of Candour and felt they would be well supported by their senior colleagues, should they be involved in an incident where something had gone wrong.

3.21 Culture & undermining (R3.3)

North and East Trainers: Trainers felt they provided a non-hierarchical team culture in Geriatric Medicine and treated the trainees and other colleagues with respect. The also felt themselves to be open and approachable. There were no undermining or bullying incidents that they were aware of that had taken place in either region.

North and East Trainees: Trainees felt well supported by their clinical team and senior colleagues. One instance of feedback being provided in an inappropriate location was highlighted in which a trainee had witnessed another trainee being given negative feedback regarding their patient reviews in the junior doctor's mess. No further detail was given, and the trainee involved in the incident was not present at the visit.

4. Summary

The visit panel found a very positive training experience was being offered to trainees in the North and East Geriatric Medicine programmes. Several positive aspects of the visit are highlighted below, along with areas for improvement, some which are drafted into requirements. Overall satisfaction in both programmes was high and trainees provided the following scores:

North Programme: 7 – 9 out of 10 with an average of 8.
East Programme: 4 – 8 out of 10 with an average of 7.

Is a revisit required? **(please highlight the appropriate statement on the right)**	**Yes**	**No** ✓	**Highly Likely**	**Highly unlikely**

Positive aspects of the visit:

- Approachable, supportive consultants
- Regional teaching mapped to curriculum (link between East and South East teaching programmes is excellent) suggest extending this to the North programme.
- Departmental teaching is excellent and mapped to curriculum.
- MDT Podcasts were highly rated.
- Regular weekly quality improvement meetings – North programme.
- Good, regular contact between Educational and Clinical Supervisors
- Access to study leave
- Sub-specialty access in East region is good
- Sub-specialty clinic access in North was commended
- Good access to workplace-based assessments in most locations
- Multidisciplinary educational opportunities including in the community
- Effective and documented handover
- Good support for trainees on maternity leave and on their return to work
- Specialty training committee in the East – highlighted as a forum where feedback is taken from trainees to trainers
- Datix awareness and feedback on a regular basis
- Good awareness of safety pathways including the use of Datix and associated feedback
- Registrar rooms

Less positive aspects of the visit:

- STC infrequency in the North (1 instance noted in the last year)
- Concern around community site, Whitehills Hospital – trainee felt unsupported with intermittent consultant support.
- Programme Induction – East – TPD contact was late for some trainees, who were 2-3 months into starting post.
- Sub Specialty access for Continence in the (North) and Tissue Viability in the (East).
- Orthogeriatric service is trainee delivered without regular consultant involvement or feedback (East)
- Multiple consultant reports – difficult to get in community placements.
- LTFT – Trainee working 80% of WTE in Geriatrics but required to contribute to GIM rota at 100%.
- Tension between geriatric medicine specialty training opportunities and general internal medicine rota commitments

5. Areas of Good Practice

Ref	Item	Action
5.1	Regional teaching mapped to curriculum (link between East and South East teaching programmes is excellent)	Consider extending this to arrangement to the North programme.
5.2	MDT Podcasts in the East Programme were highly rated.	
5.3	Regular weekly quality improvement meetings – North programme.	

6. Areas for Improvement

Ref	Item	Action
6.1	Frequency of Specialty Training Committee meetings in the North programme should be increased to at least twice per year as per Scottish Deanery guidelines.	TPD to organise.
6.2	Trainees Geriatric Medicine experience is being affected by their General Internal Medicine commitments and could be reviewed.	TPD to review in discussion with DME.

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	A written programme wide induction booklet should be produced for all new trainees to the specialty in the **East Programme.**	Before August 2020 induction	ST
7.2	Review and clarify the Clinical Supervision arrangements to ensure a clear understanding of who is providing supervision and how the supervisor can be contacted in the Orthopaedic Geriatrics Service and in Whitehills Community Hospital – **East Programme.**	5th February 2020	ST
7.3	Access to and sign off for Multiple Consultant Reports must be improved in community sites - **East Programme.**	5th February 2020	ST
7.4	Clarify the support available for trainees to perform practical procedures (such as central line insertion, pleural procedures) during general medical receiving out of hours in the **East programme.**	5th February 2020	ST
7.5	Improved access to subspecialty competences for continence in the **North Programme** and Tissue Viability in the **East Programme.**	5th February 2020	ST