Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	31 May 2019
Type of visit	Scheduled Programme Visit
Level(s)	ST3+
Specialty(s)	Geriatric Medicine
Programmes:	South East Deanery Region

South East Programme:

Board	NHS Lothian	**Hospital**	Royal Infirmary of Edinburgh at Little France Western General Hospital St John's Hospital
Board	NHS Fife	**Hospital**	Victoria Hospital Queen Margaret Hospital
Board	NHS Borders	**Hospital**	Borders General Hospital

Visit panel	
Alastair McLellan	Visit Chair – Postgraduate Dean for Quality
Reem Al-Soufi	Quality Lead
Gillian Scott	Trainee Associate
Helen Raftopoulos	Lay Representative
Heather Stronach	Quality Improvement Manager
In attendance:	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Reem Al-Soufi Dr Stephen Glen Dr Alan McKenzie
Quality Improvement Manager(s)	Heather Stronach and Alex McCulloch
Unit/Site Information	
Trainers in attendance	7 consultants, including Dr Susan Pound (existing TPD) and Dr Sarah Marrinan (successor)
Trainees in attendance	10 trainees
Feedback session:	Training Programme Directors, Associate Director of Medical Education in the South East

Date report approved by Lead Visitor	 10/07/2019

1. Principal issues arising from pre-visit review

The Deanery's quality management visit schedule aims to visit each unit/location delivering training and each training programme at least once every 5 years. Accordingly, a visit to the geriatric medicine training programme in the Deanery South East Region of Scotland took place on 31 May 2019.

Before the visit, the panel analysed the data available from the General Medical Council's (GMC's) National Training Survey (NTS) and the Deanery's Scottish Training Survey (STS). The STS collects information about the performance of a training post. A Pre-visit Questionnaire (PVQ) was also sent to trainees by the Deanery approximately 6 weeks prior to the visit and the results were shared with the visiting panel.

Responses from both the NTS, STS and PVQ data were very positive. Handover and supportive environment were indicators that strongly came across as positive, whereas perceptions about educational resources at some locations were rated less positively.

This report exclusively focuses on the delivery of the geriatric medicine specialty programme in the South East of Scotland Deanery region.

2. Introduction

Geriatric medicine is a 5-year training programme in which trainees rotate gaining competences in geriatric medicine and this is undertaken in dual training along with general internal medicine (GIM). Registrars will rotate through at least three hospitals. The hospitals in the South East of Scotland training scheme are:

- Royal Infirmary of Edinburgh (RIE)
- Western General Hospital, Edinburgh (WGH)
- St John's Hospital, Livingston (SJH)
- Victoria Hospital, Kirkcaldy (VHK)
- Borders General Hospital, Melrose (BGH).

These hospitals offer a range of different services to meet the competencies required for the geriatric medicine specialty training programme. For example, the WGH provides assessment and rehabilitation, peri-operative care, in-reach and rapid access services. The RIE provides acute elderly admissions, acute orthogeriatric services and links via Liberton Hospital to 'Hospital at Home' and Day Hospital. Liberton Hospital also gives access to integrated community services.
Of the 5 years in this training programme, typically 2 years are spent within 1 District General Hospital (includes GIM training), year 3 is spent in either RIE or WGH and the final 2 years are spent in RIE or WGH with some exposure to GIM.

Subspecialty placements are available in palliative medicine, old age psychiatry, stroke medicine and are accommodated within the 5 year training schedule; contact details of the leads for these placements are provided in the programme handbook. Access to continence placements is more difficult as there is no specific elderly incontinence service, but some exposure is accommodated via other services such as urogynaecology.

The South East of Scotland geriatric medicine programme has positively benefitted from a 100% fill rate.

This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading includes numeric reference to specific requirements listed within the standards.

3.1 Induction (R1.13)

Trainers: There is a South East of Scotland geriatric medicine programme induction pack for specialty registrars in geriatric medicine. This document provides a comprehensive overview of specialty training in geriatric medicine at sites within the South East Deanery region and demonstrates to trainees what competencies they will be able to achieve at each training location. Contact details of the leads for subspecialty placements are provided in the programme induction pack. The pack is distributed by email to trainees when they start the programme.

Each site offers a geriatric medicine departmental induction for all levels of trainees working within the department. Trainers confirmed that as educational supervisors they also have a separate face-to-

face meeting with their allocated registrars in geriatric medicine to discuss the geriatric medicine specialty programme components in more detail. Trainers at SJH also stated that there is a specific local handbook for medicine of the elderly at SJH.

In addition, the Training Programme Director (TPD), Dr Susan Pound, meets with trainees informally though a 'coffee catch up' on an individual basis, often in her own time, and does this for all new trainees starting in the programme.

Dr Susan Shenkin is the academic representative for the programme. She distributes an 'academic expectations' document because research methodology is a curriculum requirement for geriatric medicine trainees, in addition to the standard audit and quality improvement (QI) projects. Dr Shenkin supports this by offering teaching on the subject. She is also able to link trainees with an academic mentor according to their interests and is available to discuss the options for taking time out of programme, specifically for research.

All trainers felt that getting to know trainees individually was important and there was no appetite for a large regional induction meeting where all trainees attend (this was perceived as being more 'impersonal'). Trainers are keen to maintain the 1:1 set up for induction, and are proactive in getting feedback about the way induction is run. Induction was rated with pink flags 3 - 4 years ago and trainers have worked hard to improve it since. As a result, flags for induction are now white or green. Trainers said that trainees have responded positively to induction as it is run now. The upcoming TPD, Dr Sarah Marrinan, felt that there is a need to maintain what is currently in place to ensure that the programme continues to receive positive feedback about induction from trainees.

Trainees: All trainees have good advance knowledge of placements (12-18 months in advance). All were contacted well in advance of starting their posts. They all reported receiving both a programme induction (via the induction pack) and a departmental induction (in each site). Departmental inductions include discussion with the educational supervisors around what each post will provide by way of curricular objectives and outcomes expected and who to contact if there is a desire/ need for subspecialty placement while in a particular post.

Trainees were also very complimentary of the TPD, Dr Susan Pound, who took time out of her day to meet with them individually after taking up their posts. Trainees said they felt very welcomed to the programme and confirmed being contacted for their feedback about improving induction.

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

Trainers: Trainers reported that all trainees can attend formal local teaching opportunities unless they are working nights or are on annual leave. Trainers told the visiting panel that teaching is mapped to the curriculum, is trainee-led with consultant oversight, and trainees are encouraged to provide feedback after each teaching session.

Trainers told us that regional teaching is 5 days of teaching each year. Following feedback from trainees in the East region that regional teaching at the Postgraduate Centre at the RIE was difficult to attend, there are now some regional training days held in Tayside (both in Dundee and Perth) to optimise trainee attendance. The majority of teaching still takes place in Lothian. A teaching committee is in place charged with ensuring the content and smooth delivery of the teaching programme; the committee has a trainee representative from each region.

Trainees: All trainees confirmed that local departmental teaching was easy to attend, and tends to be for all grades of trainees. At the WGH trainees have tried to implement registrar-specific department teaching but this was not successful. However, a journal club for these trainees has been set up in WGH. All teaching was deemed to be of good quality and consultants support teaching through their own attendance. Teaching is not bleep free but trainees said there is a strong ethos amongst colleagues to not disturb them when they are at teaching unless it is absolutely necessary.

Trainees reported good access to regional teaching. During the GIM year of training geriatric medicine registrars appear to be able to attend around 50% of regional teaching, whereas most trainees while training in geriatric medicine posts had attended over 80%of regional teaching.

3.3 Study Leave (R3.12)

There are no challenges in supporting study leave.

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

Trainers: All clinical and educational supervisors are recognised as trainers and have time in their job plans. All supervisors have undergone the formal 'Recognition of Trainers' approval process. The educator role (and any requirements in this regard) is formally reviewed at appraisal. Educational supervisors are encouraged to formally meet with their trainees (at least twice) but this often occurs more regularly.

Trainees: All trainees reported having named educational supervisors. Some trainees said that their educational supervisors for GIM and geriatric medicine could be the same person while for others there were different educational supervisors for the two training programmes. Some trainees considered that they had a GIM supervisor, but no educational supervisor for their specialty (WGH and SJH) while another said, 'although I met my geriatric supervisor to be it was not an official meeting.'

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

Trainers: Trainers reported that they have a Specialty Training Committee (STC) which meets 4 times per year. Every unit is represented on STC and there is good engagement with the STC. Dr Susan Pound also represents Scotland on the geriatric medicine Specialty Advisory Committee (SAC) and has an update meeting with trainers annually to keep them abreast of any developments from the SAC to ensure that any changes to training that may impact on individual sites can be discussed and planned ahead. Through the STC, trainers are made aware of the various curricular requirements for trainees and any planned changes. The STC has also produced local guidance around the target numbers of clinics etc that trainees should achieve to meet their curriculum competencies.

The visit panel spoke with trainers about a wide variety of curriculum competences (falls, stroke, movement disorders, tissue viability, continence, orthogeriatrics etc). Robust discussion around these clearly demonstrated that through advanced planning of rotations and through 1:1 discussion with trainees about their individual learning needs, the entirety of the curriculum can be achieved. The programme works cohesively across all the sites to ensure this is the case and that no trainees are

disadvantaged. This is supported by the robust induction pack (previously described) that clearly outlines what curriculum competencies can be achieved during each rotation.

Trainees: Trainees confirmed receiving excellent support with trainers asking trainees what their specific needs were in each post, and enabling these to be achieved. Trainees recognised that the different training sites offered different experiences and were aware of the need to be organised and pre-plan their experience. Each post was commended for the value of its contribution to attaining curricular objectives. Trainees said that they were privileged in the geriatric medicine South East training programme because often their training is mapped out about 12 - 18 months ahead: trainees were overwhelmingly positive about having their training programme structured and planned in this way. All trainees felt that their training had been comprehensive and there were no concerns expressed about meeting curriculum competencies.

In addition to confirming access to the opportunities outlined in the introduction in section 2 of this report, the following opportunities associated with posts were also noted:

- Access to acute thrombolysis for stroke is available in RIE, BGH and VHK.
- Access to stroke rehabilitation is available in all posts.
- Access to acute orthogeriatric care and peri-operative liaison are available in BGH and RIE.
- Access to outpatient clinics is available at sites other than RIE.

The panel were told that there is no longer a consultant geriatrician in the region with a specialist interest in incontinence in the elderly, however, trainees were confident that they could still achieve this competence by attending urogynaecology clinics to obtain the experience required for their curriculum.

Trainees confirmed receiving guidance about what is expected for their curriculum.

Trainees all said that their time training was protected. All trainees have an ‘administration session’ built into their rota. At some sites this is not fixed but achieved flexibly, with all trainees able to access this time.

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

Trainers: Trainers reported that is easy for them to complete trainees' assessments. Formal feedback around the quality and content of educational supervisors' reports is provided to supervisors as a driver to improvement of electronic supervisor's reports (ESRs) and this practice has been established for quite some time and helps to calibrate trainers across the sites. The multiple consultant report (MCR) has also gained prominence and trainers are considered to do this exceptionally well.

Trainees: Trainees did not report any concerns about the quality of their assessments or the ability to achieve them.

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

Trainers and trainees outlined several opportunities for multi-professional learning. Specific examples mentioned were a weekly departmental multidisciplinary team meeting (MDT) at the WGH at which pharmacists and nurses etc are present; and multi-disciplinary learning and MDTs with advanced health practitioners during their 'Hospital at Home' experience as part of Liberton Hospital.

Trainers also said that trainees are becoming involved in the teaching of nurse practitioners studying for advanced qualifications, although we did not hear this from trainees. In summary, it was clear that the nature of geriatric medicine training ensure that trainees are involved in multi-professional learning.

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

All sites described active engagement of trainees in audit and quality improvement (QI) projects and trainees confirmed the same. Trainees are taking the initiative to continue QI projects started by previous trainees to ensure continuity of the process. Dr Susan Shenkin and Dr Terry Quinn (in the West of Scotland) run a cross-regional evidence-based medicine teaching programme and it was suggested that this was evolving to incorporate QI themes.

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)

Trainers and trainees all reported good access to clinical supervision with individuals being able to identify the different training grades either by using coloured name badges or this being identified to staff at handover as staff changes over, verbally or on a wall board. Trainees said they have never felt that they have had to cope with problems beyond their competence. If a trainee did feel this way, trainees were confident that support would be readily available and said that all consultants are accessible and approachable.

More senior trainees expressed the view that in some sites where there was 'very heavy consultant presence' they would wish to have 'more freedom' to make decisions, with tailored lessoning of supervision.

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

Trainers and trainees said there were plenty of both informal and formal feedback opportunities. This may be received in a variety of ways such as direct verbal 1:1 communication, feedback via daily ward rounds (Borders General Hospital described 'reverse ward rounds' where ward rounds are trainee-led with a supervising consultant present), the out of hours post take ward round, and (more formally) via work-based place assessments. Trainees also recognised frequent opportunities for them to receive feedback.

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

Trainers: Trainers said that they have built up a trusting rapport with trainees. They reported that trainees often provide feedback at face to face meetings that take place with them. At RIE and WGH there is also a 'chief registrar' who collects feedback about training from trainees and feeds back to trainers. Elsewhere items are tabled for discussion at STC meetings via the geriatric medicine trainee representative.

Trainees: Trainees said that educational supervisors are very proactive in requesting feedback from them. They quoted the post – Annual Review of Competence Progression (ARCP) face-to-face

meetings as an opportunity to provide feedback and also described the STC and teaching days as forums in which they provide feedback.

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

There were no specific issues raised with respect to workload or rotas for geriatric medicine training. Trainees were also happy organising their own on-call rotas and said that the on-call workload for geriatric medicine is manageable. On-call for geriatric medicine at BGH, and the weekend dayshifts for geriatric medicine in WGH & RIE are 'manageable' and do not generate any concerns from the doctors in training.

The only perceived problem with rotas was the hospital at night rota. Trainees advised that this impacts on all other rotas and unfortunately it is often distributed late. They also said that they are expected to cover the hospital at night rota across all sites (WGH, RIE, SJH) and there are issues around working in GIM in very different sites. This issue was out with the scope of this geriatric medicine programme visit, as it relates primarily to GIM.

3.13. Handover (R1.14)

Trainers: Handover was largely deemed to be effective at all sites. Trainers at VHK acknowledged that some improvements could be made with handover and there is currently a QI project underway to increase the quality of handover. At present there is a shared drive on which details about handover are recorded. BGH uses electronic files to record handover and said that a method to flag the most unwell patients is used.

SJH uses the Trakcare system and all tasks are put into Trakcare. WGH uses a shared drive and the RIE was noted to have improved recently with an electronic system used for Handover at Night.

Trainees: Trainees said that WGH has by far the most structured handover of all sites because there is always a consultant present. At the WGH trainees said that there is a formal Monday morning handover from the weekend staff to the wards at which there are limited opportunities for learning but consultants are proactive to include at least one point of learning at handover. Trainees also observed that handover at the RIE had improved recently and talked about the QI project underway

at Fife to improve handover. It was suggested that both attendance and the quality of handover could be improved at Fife and the QI project was intended to address this.

3.14. Educational Resources (R1.19)

The following was noted about educational resources:

- RIE – It was acknowledged that the computer systems are slow. The RIE does not have appropriate office space for doctors training in geriatric medicine.
- WGH – The WGH was noted to have a registrars' room with adequate computer stations.
- BGH – PCs are also slow but trainees have good office space. The BGH has simulation teaching which is organised by geriatric medicine consultants.
- SJH – acknowledged that PCs also slow but standby PCs are available for emergency situations. SJH also has simulation-based teaching and a skills lab for practical procedures.
- Liberton Hospital – has a very good registrars' room.
- VHK - trainees perceived that there was lack of office space at VHK.

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

All trainees described supportive educational supervisors and commended Dr Susan Pound for her support as a TPD. Support for flexible options such as working less than full time or support for those who had been out of programme for some time was readily available. Less than full time trainees are perceived to have equal (proportionate) access to training opportunities.

The South East of Scotland geriatric medicine programme also provides a comprehensive 'Return to Work' guide to demonstrate how trainees are facilitated back into clinical work following a career break and an example of a trainer's support for a trainee returning after a break was provided. Trainees said that there is provision for out of programme trainees to maintain regular contact with training leads if they wish to do so.

Trainers described the support for academic training provided by Dr Susan Shenkin. The trainers themselves provide career support, both advice for those who wishing to enter the specialty but also

how to pursue areas of specialist interest for trainees already in the programme, with further career guidance available through the Deanery. All trainers have completed a 'Doctor's in Difficulty course' in addition to equip them with the tools needed around providing extra support should trainees require it.

The trainees also described having access to a Balint group – and commended the support available to them through this trainee-supported initiative. The trainees also run a WhatsApp group that helps support training.

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

Trainers and trainees reported good trainee attendance and good engagement among trainers with the geriatric medicine South East programme STC (there are 3 trainee representatives on the STC).

3.17 Raising concerns (R1.1, 2.7)

Trainers: Trainers said that trainees are encouraged to raise concerns both informally and formally and are encouraged to use Datix. In NHS Lothian if trainee submits a Datix there is a new process whereby the educational supervisor gets alert from Datix and this allows feedback to be given by the educational supervisor to the trainee and is a good opportunity for reflection. The Associate Director of Medical Education in Fife will discuss Datix incidents as group or individually depending on what is appropriate. Themes from Datix are unpicked and are discussed at morbidity and mortality meetings (M+M) which trainees are invited to attend. Learning from Datix may also be incorporated into training days.

Trainees: Trainees said that to raise concerns in the first instance they would speak to consultant in charge of care, their educational supervisor, TPD, or perhaps the wider nursing team dependent on who was the most appropriate. All trainees were aware of Datix, were happy to report incidents via Datix and knew how the feedback mechanism from reporting incidents via Datix worked. One recent case was perceived to have been handled very well. Trainees were particularly complementary of the dissemination of learning from M&M meetings at the WGH where an email is sent to everyone with a copy of slides demonstrating points of learning. The same format is not followed at the RIE, but there is a Chief Registrar who communicates learning points after incidents. Trainees who worked at BGH said there is an M+M but feedback is more likely to be individual feedback as the hospital is small.

3.18 Patient safety (R1.2)

Trainers: Trainers reported site huddles, ward huddles and handover as opportunities to discuss any issues pertaining to patient safety. There were no specific issues related to patient safety raised by any of the trainers.

Trainees: Trainees also had no concerns with respect to patient safety in any of the sites in the South East of Scotland geriatric medicine programme.

3.19 Adverse incidents (R1.3)

See section 3.17

3.20 Duty of candour (R1.4)

Trainees: All cohorts of trainees said there is an open culture where they work, and they would feel supported if they were involved in an incident where something went wrong.

3.21 Culture & undermining (R3.3)

Trainers and trainers said that there is a positive team culture in all sites within the geriatric medicine programme in the South East of Scotland. All trainees reported working in a supportive and open environment. There were no concerns about undermining or bulling behaviours raised in any site.

4. Summary

Overall, this was a very positive visit. It was evident that the South East of Scotland geriatric medicine programme is a very cohesive programme with very supportive trainers and well engaged trainees who are well represented both at the STC and on the teaching committee to ensure the programme is a success. It was noteworthy to hear there is active planning of prospective rotations with trainees' awareness of future posts for up to 18 months in advance, and that the training needs of individual trainees are tailored in advance according to curriculum needs with the support of educational supervisors. The visit panel were pleased to hear that mechanisms for feedback – both from trainees

and to trainees – were well established as part of a culture supporting improvement, other aspects of which were the support to trainees around QI projects and the practice of educational supervisors being given formal feedback by ARCP panels around the quality and content of their educational supervisors' reports. We were also impressed by the availability of a trainee-led Balint group providing mutual support for doctors in this training programme.

All group of doctors were asked to rate their overall experience of their placement and the average scores are presented below:

- RIE Range = 7 – 9, Average = 8 out of 10
- WGH Range = 8 – 10, Average = 8.7 out of 10
- SJH Range = 10 – 10, Average = 10 out of 10
- VHK Range = 9 – 10, Average = 9.3 out of 10
- BGH Range = 8 – 9, Average = 8.3 out of 10

The overall range for the programme is 7-10 out of 10, resulting in an overall average for the programme of 8.6.

Aspects that are working well:

- All trainees gave very high overall satisfaction ratings for their training in all posts/sites in the South East of Scotland geriatric medicine training programme.
- The South East of Scotland geriatric medicine programme is a cohesive and very supportive programme. Trainees all described very supportive and approachable consultants and commended, in particular, Dr Susan Pound for her personal commitment and support to them as TPD including 'coffee conversations' in her own time and exemplary support for LTFT training.
- Programme induction and associated handbook that include comprehensive curricular mapping of training objectives and opportunities to sites.
- The training needs of individual trainees are tailored in advance with educational supervisors able to support and help trainees plan their training according to curriculum needs.

- Regional teaching programme works well. Trainees are able to access regional teaching regularly and specialty registrars are involved in the design and delivery of the regional teaching programme.
- The prospective rotational management with trainees' awareness of future posts for up to 18 months in advance was greatly valued by trainees.
- Trainee-led Balint group providing mutual support for doctors in this training programme.
- Trainees were all able to describe ample opportunities for multi-professional learning.
- Trainees have a half-day for 'administration' built into their schedules; at some sites this is not fixed, but achieved flexibly, but all trainees were able to access this time.
- Formal feedback around the quality and content of educational supervisors' reports is provided to supervisors as a driver to improvement of ESRs; this practice is well established.

Aspects that are working less well:

- Lack of office space for doctors in training in Geriatric Medicine at the RIE.

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

5. Areas of Good Practice

Ref	**Item**	**Action**
5.1	Coffee conversations with trainees by the TPD.	
5.2	Active planning of prospective rotations with trainees' awareness of future posts for up to 18 months in advance.	
5.3	Formal feedback around the quality and content of educational supervisors' reports is provided to supervisors as a driver to improvement of ESRs.	
5.4	'Reverse ward rounds' (BGH).	
5.5	Trainee-led Balint group.	
5.6	Half day 'administration' sessions built into rotas.	

6. Areas for Improvement

Ref	Item	Action
6.1	Specialty registrars should have separate educational supervisors for Geriatric Medicine and for General Internal Medicine.	

7. Requirements - Issues to be Addressed

Ref	Issue	By when
7.1	The lack of access to office space with IT for trainees in geriatric medicine must be addressed in RIE.	28 February 2020