Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	24th April 2019	**Level(s)**	ST
Type of visit	Triggered Programme	**Hospital**	All West of Scotland training locations
Specialty(s)	Geriatric Medicine	**Board**	NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde, NHS Forth Valley and NHS Lanarkshire

Visit panel	
Dr Reem Al- Soufi	Visit Chair – Associate Postgraduate Dean for Quality
Dr David Marshall	Associate Post Graduate Dean for Medicine
Hugh Paton	Lay Representative
Dr Alice McGrath	Training Programme Director
Alex McCulloch	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 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	7 including Training Programme Director
Trainees in attendance	11

Feedback session: Managers in attendance	

Date report approved by Lead Visitor	17th May 2019 Dr Reem Al-Soufi

1. Principal issues arising from pre-visit review

A deanery visit to the West of Scotland Geriatric Medicine Programme was triggered at the Medicine Quality Review Panels in September 2018 due to the number of red flags raised within the following sites in the National Training Survey in 2018:

University Hospital Ayr – 2016 – 2018 Aggregated red flags for:

Overall Satisfaction
Clinical Supervision
Clinical Supervision out of hours
Reporting Systems
Adequate Experience
Supportive environment
Local Teaching
Regional Teaching

Forth Valley Royal Hospital – 2016 – 2018 Aggregated red flags for:

Overall Satisfaction
Adequate Experience
Local Teaching
Regional Teaching

Inverclyde Royal Hospital – 2016 – 2018 Aggregated pink and red flags for:

Overall Satisfaction – Pink
Reporting Systems – Pink
Induction – Pink
Adequate Experience – Pink
Feedback – Pink
Regional Teaching – Red
Study Leave – Red

The Training Programme Director (TPD) has advised the Deanery that the red flags highlighted above for University Hospital Ayr and Inverclyde Royal Hospital are probably in relation to General Internal Medicine experience as Geriatric Medicine trainees do not rotate to either site for Geriatric Medicine. The visit panel would explore this possibility further during the visit and will take the opportunity to gain a broader picture of how training is carried out within the programme. The visit panel will identify any areas of innovation and good practice for sharing more widely.

This visit is one of 4 visits to all the Geriatric Medicine Programmes across Scotland, taking place between April and May 2019.

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.

Geriatric Medicine in the West of Scotland is a five-year training programme, designed to deliver comprehensive exposure to all aspects of Geriatric Medicine combined with General Internal Medicine.

3.1 Induction (R1.13)

Trainers: The programme induction provided for trainees includes an individual 1-2-1 meeting with the TPD in August, during this meeting trainees are provided with a handbook and discuss their training plans with the TPD. Departmental induction was similar across the training sites and broadly consisted of provision of a handbook and face to face meetings with trainers.

There have been recent developments to programme induction such as the introduction of a buddy system, where new ST3 trainees are paired up with more experienced trainees to support them in the early weeks of their training, which is in its infancy and a move to online Geriatric Medicine induction being developed at the Queen Elizabeth Hospital (QEUH).

Trainees: Trainees felt the programme induction, inclusive of a handbook was good. They also confirmed the 1-2-1 meetings with Training Programme Director (TPD) and advised the TPD had sought their feedback on the programme induction provided. The trainees had no improvements to suggest in relation to programme induction. However, departmental induction at QEUH did not explain the roles and responsibilities of trainees acting as the ‘Med Reg’ in the IAU and trainees suggested covering the topic during induction would be helpful.

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

Trainers: Local Geriatric Medicine teaching mapped to the curriculum was provided to trainees in each training location and the following was offered to trainees:

Forth Valley Royal Hospital (FVRH): Friday meeting where relevant cases are presented and external speakers are invited to deliver talks, in addition to quarterly departmental meetings that includes Morbidity and Mortality M&M as well as Quality Improvement sessions where trainees have the opportunity to present their projects.

Royal Alexandra Hospital (RAH): Local departmental teaching provided weekly on a Friday and Wednesday which is open to trainees.

Glasgow Royal Infirmary (GRI): Monday departmental meeting which is open to trainees, monthly M&M meetings which trainees present cases for discussion, hospital grand rounds and Stroke Multi-Disciplinary meetings.

University Hospital Wishaw (UHW): Monday lunchtime sessions delivered by consultants, higher trainees (ST) also participated in the delivery of some of the junior trainees teaching sessions. Quarterly M&M meetings, Wednesday departmental meetings and Friday grand rounds.

University Hospital Hairmyres (UHH): Wednesday grand rounds, Thursday lunchtime, monthly M&M and Friday departmental Geriatric sessions.

Queen Elizabeth University Hospital (QEUH): Thursday lunchtime sessions, 4 monthly M&M and Friday grand rounds. There are 2 monthly CPD meeting for Consultants and STRs

Although local departmental teaching was not bleep-free across all sites, trainers felt they had good access to it and that trainees being bleeped out was an infrequent occurrence.

In addition to the departmental teaching, a 5-year regional teaching programme mapped to the curriculum was also provided for trainees and organised by the TPD where the different training sites take turns at hosting.

Trainees: Trainees confirmed they were able to attend formal timetabled local departmental Geriatric medicine teaching across all the West of Scotland training sites. Trainees received on average 1 hour per week of local Geriatric Medicine teaching. An improvement to local teaching at UHW would be to review the rolling teaching programme; trainees felt sessions were often repeated and were sometimes aimed at trainees of a more junior level. The regional teaching programme was highly regarded by the trainees for its quality and coverage of the curriculum.

3.3 Study Leave (R3.12)

Trainers: The trainers were not aware of any issues with trainee access to study leave.

Trainees: Trainees across most of the sites were able to request and take study leave, however trainees based in IRH, UHM and UHH described the busy workload in General Medicine to have affected 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)

Trainers: Trainers confirmed that trainees are allocated Educational Supervisors before they start their posts, Educational Supervisors were allocated for a full year and generally their Clinical Supervisors for 6 months at a time. Initial meetings would take place between the trainees and Educational Supervisors in their first couple of weeks in post. Trainers were made aware of trainees with known concerns by the TPD. All trainers present confirmed they had time in their job plans to undertake their educational role. Trainers' roles were reviewed through the SOAR annual appraisal process.

Trainees: Trainees confirmed they had all been allocated Educational and Clinical Supervisors and had initial meetings with them.

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

Trainers: Although not all sites were in a position to provide experiences to cover the entire curriculum requirements for Geriatric Medicine, balance was achieved by allowing the trainees flexibility of movement across the region to achieve competences relevant to their stage of training. Trainers regularly discussed their trainees' needs across the sites and would make arrangements for trainees to go to where they could get the experience they required.

Trainees: Trainees described the flexibility of the hospitals across the region in providing the experience they required to meet their curriculum requirements as excellent. The experience of some the trainees when based in the smaller district general hospitals in accessing clinics, could be different to those in the bigger teaching hospitals. Sites where clinic access was highlighted as "difficult to get" by trainees were UHH, UHW and UHM as compared to their colleagues in GRI, QEUH and UHC where trainees were allocated time on their rotas to attend clinics.

Trainees generally described good balance between time developing as a doctor and time spent on other non-educational activities. There were exceptions to this experience and trainees who were based at or had rotated through UHW, UHM, and University Hospital Crosshouse (UHC) described acting down as FY1s to complete ward-level duties following ward rounds on regular basis, this was perceived to be of no training value.

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

Trainers: Trainers were not aware of trainees having any difficulties completing workplace-based assessments and felt there were opportunities for them to do so across the sites in the programme.

Trainees: Most trainees did not report any difficulties with completing workplace-based assessments, although it was highlighted trainees were not able to participate in ward rounds due to service pressures in UHC and this made it difficult for them to get workplace-based assessments signed off.

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

Trainers: Trainers felt multi-disciplinary learning occurred regularly both formally and informally through all the sites in their programme.
Trainees: Trainees did not provide any specific examples of multi-disciplinary working but did feel it happened on regular basis across all sites.

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

Trainers: The TPD advised that an audit had been conducted of initial trainee ARCP outcomes. The most common reason for an outcome 5 in previous years had been the lack of the use of the audit assessment tool. Trainees had usually completed an Audit or QI project but failed to get this formally assessed. As a result, a checklist had been created to assist trainees in finalising their projects to facilitate completion of the audit assessment documentation.

Trainees: Trainees felt they had adequate opportunities to engage in quality improvement projects and audit.

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: Due to the number of training sites across the programme, there was variation in the methods staff at the hospitals used to differentiate between different grades of trainee. Some sites, such as the Lanarkshire hospitals operated a coloured badge system, whilst others done so through word of mouth or through one to one working with their consultants. Some had implemented the “Hello my name is” initiative. Trainers were not aware of instances where trainees have had to cope with problems that were beyond their competence or experience.

Trainees: Trainees reported good access to senior support both during the day and in the out of hours period within Geriatric Medicine across the different sites. Several trainees reported incidents of being expected to complete pleural or central line procedures without supervision, which they felt was beyond their competence or experience. However, this was whilst on General Internal Medicine rotations rather than Geriatrics. Trainees felt their Geriatric consultant colleagues were accessible and approachable across the training sites.

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

Trainers: Feedback was provided to trainees through a variety of methods. Face-to-face on the job feedback was provided regularly in some sites such as the RAH and QEUH, and during ward rounds across most sites.

Trainees: Trainees confirmed they received regular and meaningful feedback at most sites although feedback provided to trainees at UHC was highlighted as variable and that opportunities to work alongside consultants were infrequent, resulting in reduced face-to-face interactions.

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

Trainers: Trainers confirmed there are 2 trainee representatives that are members of the Specialty Training Committee, who would bring any trainee concerns to the committee for discussion. Some of the training sites had appointed Chief Residents who represented trainees at hospital management meetings. The training survey results were also discussed at the Specialty Training Committee.

Trainees: Trainees felt they could feedback any concerns they had around their training to the Trainee representatives on the specialty training committee.

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

Trainers: Trainers acknowledged there was a heavy workload across the sites in General Internal Medicine which could affect the trainees' Geriatric Medicine experience. A re-design of the rota had taken place in FVRH with the aim of improving trainees' experience. There were no vacancies in the Geriatric Medicine programme, but trainers highlighted that trainees were sometimes expected to cover training vacancies at a more junior level, such as at Foundation and Core levels.

Trainees: Trainees felt their rotas to be manageable during the day but it could be more variable in the out of hours period when they cover General Internal Medicine. The trainees felt that despite this increase in out of hours workload there was no compromise to patient safety or quality of training.

3.13. Handover (R1.14)

Trainers: Handover was felt to be robust across most sites within Geriatric Medicine. Different methods were used across the sites, with some being documented on paper and others through the Trakcare system. In addition to handover, safety huddles/briefs were conducted across the sites which were felt to provide learning opportunities for trainees.

Trainees: Handover was felt to be safe and effective across most sites with the exception of handover within GRI. It was described as chaotic and non-consultant led. However, it was acknowledged that steps were taken to address the situation in GRI and the site started using Trakcare to document handover.

3.14. Educational Resources (R1.19)

Trainers: Not asked.

Trainees: Facilities and space were thought to be adequate across most of the training sites, although space for completing administrative work was highlighted as limited in UHC, UHH and UHM.

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

Trainers: Concerns around trainees who were struggling with their training were highlighted by the TPD, who would contact the trainers to inform them and to discuss how best to support the affected trainees. The Performance Support Unit at the deanery was identified as another resource that trainees could be referred to.

Trainees: Support for trainees who were struggling with the job or health was thought to be adequate. Of the trainees' present, 3 trainees worked less than full-time and had felt supported to do so. Trainees raised some concerns around how the support was provided for them on return to their training after maternity leave, this was in regard to local site support from HR as opposed to support within the programme. Trainees who had returned from maternity leave reported a reluctance of HR in some sites to engage with them before they returned to work, including a request to see occupational health prior to starting work. A trainee also described lack of phased return to work and that she was allocated night shifts despite only being back at work for 4 days, after 1 year's maternity leave.

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: Trainers advised that Quality of training was discussed regularly at the Specialty Training Committee, discussion also took place around the National Training Survey and Scottish Training Survey results and the data generated as a result.

Trainees: Not covered.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Not covered.

Trainees: Not covered. (covered in Feedback from Trainees session and Duty of Candour)

3.18 Patient safety (R1.2)

Trainers: Trainers felt the environments they worked in were safe for both patients and trainees. Across the training locations within Geriatric Medicine, most did not board their patients out to other wards. At the QEUH there was a designated boarding team that managed boarded patients, which sometimes involved the trainees in Geriatric Medicine.

Trainees: Of the trainee's present, most would not have any concerns if a patient or relative was admitted to the hospital they worked in except for some of the wards at University Hospital Crosshouse.

3.19 Adverse incidents (R1.3)

Trainers: Datix was highlighted as the main reporting method for adverse incidents. Feedback on Datix reporting was discussed mostly through M&M meetings, although it was highlighted that Datix feedback was not built into the M&M structure at the QEUH.

Trainees: The trainees confirmed Datix as the main reporting took for adverse incidents. Trainee feedback on Datix incidents was described as variable across the training locations. Some sites would discuss Datix incidents at M&M meetings. Lanarkshire was an exception in that Datix completed by trainees would automatically generate a link to their ES and outcome will be emailed to ES to discuss with their trainees.

3.20 Duty of candour (R1.4)

Trainers: Trainers felt Duty of Candour was part of the culture across all sites within Geriatric Medicine and trainees were supported and encouraged to discuss any incidents where things had gone wrong with their Educational and Clinical Supervisors.

Trainees: No concerns were raised by trainees, they 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)

Trainers: Trainers were not aware of any undermining or bullying incidents. The TPD confirmed he had not received or was aware of any incidents or bullying or undermining behaviours in Geriatric Medicine. An incident was mentioned that had taken place at FVRH and was reported locally, it had taken place during a GIM shift, the trainer advised that this had been reported and resolved locally to the satisfaction of all parties involved.

Trainees: Across Geriatric Medicine, trainees confirmed their consultant colleagues to be supportive and approachable. Concerns were raised around the interface with General Internal Medicine which was described as “tense”, and trainees felt that lack of understanding of their specialty was behind this tension. There were two sites (UHC and IRH) where trainees felt some of the comments they had received were not constructive.

4. Summary

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

The visit panel found trainees in the West of Scotland Geriatric Medicine programme were receiving a very positive training experience, this is evidenced by the high overall satisfaction scores they gave their training programme which ranged between 7 – 10 out of 10 with an average score of 8 out of 10. The visit panel identified many positive aspects of the training programme and some areas for improvement which are highlighted below.

Positive aspects of the visit:

- Approachable and supportive Geriatric Medicine consultants across the different sites with clear commitments to high quality training.
- Trainees feel valued by their trainers and are given regular and meaningful feedback on their performance in Geriatric Medicine.
- Trainees are provided with a wide range of opportunities to cover the breadth of their curriculum across the different sites and achieve their competences flexibly by the end of the 5 years.
- Comprehensive induction programme with an updated booklet and face-to-face meeting that is highly rated by trainees.

- A comprehensive regional teaching programme which is mapped to the curriculum and is rated by the trainees as excellent.

- A wide spectrum of formal teaching opportunities that are available for trainees across all sites.

- Feedback to Geriatric Medicine trainers and TPD is achieved through trainee representatives on the Specialty Training Committee (STC) and chief residents' fora.

- Pairing ST3 with a more senior trainee as a "mentor" is a promising initiative. Early phase at the time of the visit.

- Wide range of multi-professional learning opportunities are available within Geriatric Medicine.

- Good access to clinics in QEUH, GRI and UHC where trainees are rostered to attend them.

- Trainees in NHS Lanarkshire sites receive feedback on incidents they report through Datix as the system creates an automatic notification to the trainee's supervisor.

Less positive aspects of the visit:

- Trainees based in the District General Hospitals (with the exception of University Hospital Hairmyres) reported working in wards with inadequate foundation doctors' cover, leading to Specialty Trainees acting down as FY1s, which is detrimental to their training.

- Trainees on GIM rotations felt they were working beyond their level of competence when performing unsupervised pleural procedures and central-line insertion, particularly out of hours.

- There was a reported incident of a perceived undermining remark made to one of the trainees. Further details will be shared with the relevant DME separately to protect the anonymity of the trainee.

- The interface between GIM and Geriatric Medicine was described as 'tense' and the trainees felt that behind this tension is a lack of understanding of their specialty. Trainees perceived their GIM experience in IRH and UHC to be particularly unfriendly.

- There was inconsistency in receiving feedback from Datix reporting system. NHS Lanarkshire was an exception.

- Support for trainees returning to practice after a career break e.g. Maternity Leave before starting night shifts was inconsistent and a phased return to OOH duties was not always granted.

Site specific:

- Issues with accessibility to clinics in UHH, UHM and UHW.
- Obtaining workplace assessments requiring consultant supervision in UHC has been an issue.
- QEUH departmental induction does not cover roles and responsibilities of trainees when working in IAU as ‘Med Reg’.
- Handover remains an issue in GRI – described as ‘chaotic’.
- No desk space in UHH, UHM or UHC for trainees to perform non-clinical duties.
- Departmental teaching at UHW and UHC was felt to be aimed at more junior level and was thought to be repetitive (same presentation repeated twice or 3 times in the year).
- Study leave was thought to be challenging to obtain for regional teaching in IRH, UHM and UHH due to ward workload.

5. Areas of Good Practice

Ref	Item	Action
5.1	Pairing ST3 with a more senior trainee as a “mentor” is a promising initiative. Early phase at the time of the visit.	
5.2	A comprehensive regional teaching programme which is mapped to the curriculum and is rated by the trainees as excellent.	
5.3	Trainees are provided with a wide range of opportunities to cover the breadth of their curriculum across the different sites and achieve their competences flexibly by the end of the 5 years.	
5.4	Trainees in NHS Lanarkshire sites receive feedback on incidents they report through Datix as the system creates an automatic notification to the trainee’s supervisor.	

6. Areas for Improvement

Ref	Item	Action
6.1	There was inconsistency in receiving feedback from Datix reporting system. NHS Lanarkshire was an exception.	Consistency around feedback on Datix should be improved, NHS Lanarkshire's process for providing feedback was highlighted as good practice.
6.2	Support for trainees returning to practice after a career break e.g. Maternity Leave before starting night shifts was inconsistent and a phased return to OOH duties was not always granted.	This was highlighted by trainees based at the Queen Elizabeth University Hospital and Glasgow Royal Infirmary.
6.3	QEUH departmental induction does not cover roles and responsibilities of trainees when working in IAU as 'Med Reg'.	To be reviewed by TPD and DME.
6.4	Departmental teaching at UHW and UHC was felt to be aimed at more junior level and was thought to be repetitive (same presentation repeated twice or 3 times in the year).	To be reviewed by local Geriatric Medicine leads

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Alternatives to doctors in training must be explored and employed to address the chronic inadequate staffing in the junior rota that is impacting on the training of ST trainees who are being used to cover FY1 duties at the following sites (Inverclyde Royal Hospital, University Hospital Crosshouse, University Hospital Wishaw and University Hospital Monklands)	29th January 2020	ST
7.2	Doctors in training must not be expected to work beyond their competence. (Trainees on GIM rotations felt they were working beyond their level of competence when performing **unsupervised** pleural procedures and central-line insertion, particularly out of hours). Contingency plans should be in place to provide a safe service if the trainee acting as the Med Reg is not able to independently perform such procedures.	29th January 2020	ST
7.3	Relationships at the Geriatric Medicine – General Internal Medicine interface must be improved through improving understanding of Geriatric Medicine as a specialty and curriculum requirements amongst non-geriatric medicine colleagues supervising Geriatric Medicine trainees. This applies to all sites with special emphasis on University Hospital Crosshouse and Inverclyde Royal Hospital.	29th January 2020	ST

7.4	Ensure that service needs do not prevent trainees from attending clinics and other scheduled learning opportunities in University Hospital Hairmyres (UHH), University Hospital Monklands (UHM) and University Hospital Wishaw (UHW).	29th January 2020	ST
7.5	A process for providing feedback to doctors in training on their input to the management of acute cases must be established. This should also support provision of WPBAs in University Hospital Crosshouse	29th January 2020	ST
7.6	Handover processes in Glasgow Royal Infirmary must be improved to ensure there is a safe, robust handover of patient care with adequate documentation of patient issues, senior leadership and involvement of all trainee groups who would be managing each case.	29th January 2020	ST
7.7	Access to a more formalised study area/room with computers must be provided for trainees in University Hospital Hairmyres, University Hospital Monklands and University Hospital Crosshouse.	29th January 2020	ST
7.8	Trainees must be given protected study leave to attend mandatory regional teaching in Inverclyde Royal Hospital, University Hospital Monklands and University Hospital Hairmyres.	29th January 2020	ST