Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	22nd May & 5th June 2018	**Level(s)**	ST
Type of visit	Programme	**Hospital**	Victoria Hospital, Kirkcaldy Aberdeen Royal Infirmary, Ninewells Hospital Dundee, Western General Hospital Edinburgh, Royal Infirmary of Edinburgh, Queen Elizabeth University Hospital Glasgow, Glasgow Royal Infirmary, Royal Alexandra Hospital, Paisley, Institute of Neuroscience Glasgow, Royal Hospital for Children Glasgow, Forth Valley Hospital Larbert, Hairmyres Hospital East Kilbride, Monklands Hospital Airdrie & Golden Jubilee Hospital Clydebank.
Specialty(s)	Intensive Care Medicine	**Board**	NHS Fife, Grampian, Tayside, Lothian, Greater Glasgow & Clyde, Forth Valley, Lanarkshire & National Waiting Times Centre

Visit panel	
Dr Claire Vincent	Visit Lead & Associate Postgraduate Dean – Quality
Dr Fiona Cameron	Training Programme Director, Anaesthetics, East Region
Mr John Adams	Lay Representative
Dr Stephen Davidson	Trainee Associate
Miss Kelly More	Quality Improvement Manager
In attendance	
Ms Lorna McDermott	Quality Improvement Administrator

Specialty Group Information

Specialty Group	Emergency Medicine, Anaesthetics & Intensive Care Medicine	
Lead Dean/Director	Professor Ronald MacVicar	
Quality Lead(s)	Dr Kim Walker & Dr Claire Vincent	
Quality Improvement Manager(s)	Miss Kelly More	
Unit/Site Information		
Non-medical staff in attendance	n/a	
Trainers in attendance	East - 10 (5 in the room & 5 via VC) West 11 (including 2 from NHS Lanarkshire who do not currently have trainees but have done in the past)	
Trainees in attendance	East - 9 (3 North, 2 South East & 4 East) West – 11	
Feedback session: Managers in attendance	East - Medical Education Manager NHS Lothian, Associate Director of Medical Education NHS Lothian, Divisional General Manager NHS Grampian and Associate Director of Medical Education NHS Grampian. West – Director of Medical Education NHS Forth Valley and Associate Director of Medical Education NHS Greater Glasgow & Clyde	

Date report approved by Lead Visitor	11/06/18

1. Principal issues arising from pre-visit review

For this specialty, due to small numbers of trainees on each site, it is difficult to obtain feedback from the General Medical Council (GMC) National Training Survey (NTS) or the Scottish Training Survey (STS). Therefore, it was decided to undertake a national visit covering all four programmes. The purpose of the programme visit is to meet with all trainee grades and trainers to review training, education and experience against the requirements of the GMC's Standards for Medical Education and Training.

The visit team also took the opportunity to gain a broader picture of how training is carried out within the departments and to identify any points of good practice for sharing more widely.

2. Introduction

The visit was split over two days, the first day covering trainees on the east coast of Scotland in the Fife, Grampian, Tayside and Lothian health boards which cover the north, east and south east regional programmes. The second day covering trainees on the west coast of Scotland in the Greater Glasgow & Clyde, Forth Valley and National Waiting Times Centre health boards. On both days the visit team met with specialty trainees as well as trainers.

A summary of the discussions from both days has been compiled under the headings in section 3 below. 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: Trainees in the east have a joint induction with anaesthetics over one morning which also covers intensive care medicine (ICM). They also have an option to have a placement in the department one week prior to starting in post.

Trainees in the north have mainly worked in the department before joining. They have a conversation with the training programme director (TPD) who runs through the programme with them.

Trainees in south east have an ICM programme induction day. They meet with the college tutor, the regional advisor and other trainees already in the programme. They are provided with information on the programme and the support systems available to them.

The TPD in the west region meets with the trainees individually within a week of them starting in post (usually before that). The meeting covers local information & training plan. An induction with all trainees has been discussed but not deemed feasible due to the trainee numbers.

Trainees: Trainees in the north and east met with their educational supervisors to discuss what would be covered in their training. Both regions have small departments with less trainees so they were unsure how a programme specific induction would work.

Trainees in the south east meet with the college tutor, the regional advisor and other trainees already in the programme. They are given information on the programme and shown examples of completed e-portfolios so they are clear on what is expected of them. They found the induction very useful.

Trainees in the west meet their TPD individually to run through their training plan & e-portfolio. The TPD sends round an email to the other trainees introducing the new trainee(s) to them which then leads to them being added to the what's-app group.

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

Trainers: The south east run regional teaching one day every two months which is mapped to the curriculum and trainees are given study leave to attend. They also run a journal club and simulation sessions. Trainees working in Fife can access tracheostomy teaching should they wish to do so.

The north and east regions both operate on single sites so do not run regional teaching. If trainees are in a dual training programme they can still access the ICM teaching but depending on their rota in the other department it is not always possible to attend. Both regions are linking in to the west of Scotland Royal College teaching sessions via VC.

The north region also has monthly CME meetings, a journal club and a few sessions of simulation teaching on a Wednesday afternoon.

The east region has multi-disciplinary teaching airway teaching run in the clinical skills centre as well as annual paediatric critical care training.

The west region has access to the Scottish ICM teaching events as well as the Royal College of Physician evening sessions. There is also regional teaching which focuses on curriculum content and exam preparation. Trainees can also attend local departmental teaching which is said to be of good quality. There is also simulation training available which takes place twice a year and focuses on human as well as clinical factors.

Trainees: Trainees in the south east attend regional teaching six times a year and there are no issues with getting time off to attend. In future, some of these sessions will be trainee led and focus on career development.

Trainees in the east all attend the national (SICS) teaching days in addition to having weekly teaching on a Thursday lunchtime. They will be joining the west of Scotland regional teaching which is said to be useful exam preparation.

Trainees in the north also attend national teaching days as well as a monthly CME meeting. They would like to have more opportunities to access simulation based teaching.

Trainees in the west attend 2 full days teaching every 12 months, the morning is an educational session and the afternoon is exam preparation. Trainees also attend the Scottish ICM society teaching 2-3 times a year, west of Scotland Royal College of Physician teaching evenings as well as local teaching in their department. They provide feedback on the teaching provided.

3.3 Study Leave (R3.12)

Trainers: Trainers in the south east had no issues in the management of study leave.

Trainers in the east found the budget to be tight but had additional monies from the endowment funds.

In the north the approval of study leave is managed by the TPD in another specialty which can make the approval process tricky to manage.

In the west there are no issues in letting trainees away for study leave, trainees use the budget as they see fit although it is recognised that dual programme trainees would benefit from more money.

Trainees: None of trainees on the east coast had any issues in getting study leave approved by the ICM consultants. Other departments were less keen to support study leave for ICM. Formal supportive discussions had taken place around this with emergency medicine in the north.

In the west there were no issues in having study leave approved and this was always dealt with quickly. Concerns were expressed about the level of funding available. Perception of this varied between regions. Some trainees were given a specific budget and others were given access to the departmental ‘pot’ of study leave money which was said to work well.

All dual trainees expressed concerns about the amount of money available and the time allocation. It was said to be difficult to fit in enough relevant courses for both their training specialties.

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

Trainers: In the east all consultants are educational supervisors and who is the supervisor for each trainee depends on which programme the trainees work in. Time for their educational role is included in their specific programmed activity (SPA) time.

In the south-east supervision is shared between the sites and supervisors are allocated around 6-8 weeks before trainees join a department. The TPD has a 0.5 programmed activity allocation in their job plan with a 0.5 per 2 trainees' allocation for the educational supervisors. This time is part of SPA and can be negotiated if necessary.

In the north the TPD supervises all the pure ICM trainees although the plan is to spread this out amongst the other consultants. Time for their educational role is included in their SPA time.

Trainees in the west are allocated a supervisor for their stage 1 training which changes when they move to stages 2 & 3. Trainees are made aware of who their supervisor is before joining the programme. Information is shared about trainees between supervisors unless a trainee specifically requests it not to be. Staff have attended the relevant training and those in Forth Valley, Golden Jubilee and Lanarkshire have specific time in their job plans however those in Greater Glasgow & Clyde do not.

Trainees: Trainees in all regions had met with the educational supervisors either two or three times a year, they had agreed learning plans with them and found the meetings useful.

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

Trainers: The minimum ICM rotation is 3 months and the specialty is competency rather than numbers based. Trainees in the east have individual educational contracts and these are shared with all consultants in the department so everyone is aware of what trainees need to learn. Many competencies are covered locally but trainees rotate to Aberdeen for extracorporeal membrane oxygenation (ECMO) experience, to Glasgow for cardiac and to Edinburgh for neurology and paediatric experience.

In the south-east curriculum summaries are available on line on a shared drive so everyone can access them. All of the curriculum can be delivered within the region. Stage 2 can be challenging to deliver especially for dual trainees as the curriculum is still in its infancy.

In the north educational supervisors have the same trainee level each year so are aware of the curriculum. There is a six bedded cardiothoracic unit and enough neurology cases on the general ICU so it is possible to deliver these competencies locally. With enough notice they are supportive of trainees who wish to gain these competencies in other centres. Paediatrics ICM experience must be gained elsewhere.

In the west consultants in all departments are made aware of the skill level and requirements for each trainee either by email or on a shared drive. Trainees can achieve all required competencies in the region although at times it can be difficult to accommodate all the sub-specialty training requirements and this difficulty could increase as trainee numbers increase or with an increased demand from the other programmes.

Trainees: Trainees in the south east feel that they have a good mix of experience, taking responsibility is encouraged but support is available when required. If they needed more experience in a particular area such as paediatrics then this would be arranged either in the south east or the option of Glasgow is available.

In the north they feel they are meeting their competency requirements. They gain a good mix of experience and arrangements are in place to gain further experience in areas such as cardiac and neurology in other centers. For dual trainees the difficulty is often being released from the on-call component of their dual specialty which creates difficulties in training in other centres.

In the east as in the other regions, the trainees feel that they have a good range of experience and are supported to go elsewhere to gain stage 2 experience in cardiac, paediatrics and neurology. All trainees in the programme would like to be able to take referrals to the unit and suggested that an on-call page would be useful in facilitating this.

In the west all areas of the curriculum can be covered within the region and all specialties that the trainees are working in are aware of their individual learning needs. However, trainees at stage 3 feel that as their placements are 3 months long they do not feel this is beneficial to gaining the most from working in a in a pre-consultant role as it takes a while for staff to get to know them. This also limits their ability to take part in any meaningful quality improvement work during this time. They feel that the training is good for developing general ICM doctors but not so good for developing specialists in specific areas.

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

Trainers: Consultants have all had training in how to complete assessments.

Trainees: None of the trainees in any region had issues with getting their assessments signed off.

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

Trainers: In the east physios, pharmacists and dieticians take part in some of the ward rounds and some teaching sessions are attended by nursing staff. In the south east including Fife some teaching sessions and the safety huddle is multi-disciplinary. Ward rounds and simulation sessions are also multi-disciplinary.

In the north ward rounds, joint teaching sessions and the departmental Tuesday morning meeting are multi-disciplinary. Physio staff attend trainee induction.

In the west simulation training is multi-disciplinary.

Trainees: In the south-east the simulation training is multi-disciplinary. In the east the morbidity and mortality (M&M) meetings are attended by nursing staff and in the north teaching sessions are attended by nursing and physio staff.

In the west ward rounds and weekly departmental meetings are attended by staff from all disciplines. Simulation training is also multi-disciplinary. Some trainees have attended this and found it useful, others struggled to fit it in with other competing priorities.

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

Trainers: North trainees have SPA time to do projects. South east trainees link in with core QI projects at the start of their block.

Trainees: Trainees in the north are given access to a list of projects that they can choose to work on. In the east trainees knew who the QI lead was if they wanted to start/continue a project and in the south-

east trainees were contacted by one of the QI leads before they started in the department to ascertain what their interests were.

In the west the duration of their placements means it can be difficult to do any meaningful QI work however they did suggest that if they worked more collaboratively as a trainee group that may help.

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: Trainees in the east and north are well supported. North trainees also have their photo taken and this shared with the rest of department so that everyone knows who the trainees are. In the south east, the trainees wear different colour coded badges according to their stage of training. The escalation policy is clearly visible to all staff so they know when to seek help.

Trainees in the west have a clinical supervisor on each site that they are placed in. Trainees have different coloured badges depending on the level of training they are at. This is being rolled out across the region and be completed by August 2018. Trainees are supervised most of the time they are on shift and consultants are contactable from home out of hours on sites without 24/7 cover.

Trainees: None of the trainees had any issues with knowing who their supervisor was or having to deal with problems beyond their experience. In the west some trainees expressed concern about the August changeover period when they may be on shift with a more junior trainee who has little ICM experience and they as the senior trainee are expected to cover ICU/HDU & hold the arrest bleep. They did say that if they needed help or an extra pair of hands this was available.

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

Trainers: Trainees in the south east are encouraged to discuss cases. In the north the trainee numbers are small and staff interact with each other regularly. In the east trainees receive regular informal feedback and if there are issues identified then these are raised with the trainee in question.

In the west outside of the educational supervision meetings where feedback is provided, feedback is delivered regularly on an informal basis so that any less positive messages can be dealt with in a timely manner.

Trainees: Trainees in the east and south east get regular informal feedback and more formal feedback via their workplace based assessments.

In the north the provision of feedback was variable so a trainee had introduced a new form for completion which should hopefully ensure the provision of more regular feedback.

In the west feedback can be variable depending on where you are working and who you are working with but is generally useful where provided. As the specialty is consultant led immediate feedback does tend to be provided. Mid-point reviews with an educational supervisor can be useful as this can be an opportunity to receive feedback on how to improve although recognise that this can be difficult to do on a 3-month placement.

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

Trainers: The north region recently carried out a trainee survey out of which came the fact that trainees felt that they did not receive regular feedback therefore a new form is being trialled which encourages consultants to provide more regular feedback.

The east team are a small department and trainees are often asked via their educational supervisor if there is anything that could be done better. Trainees needs are facilitated.

In the south east trainees are asked at their end of placement meeting if there is anything that could be done better. Trainees can access welfare guardians who are independent of the management and educational structures. Trainees are also asked to complete a questionnaire and Fife were particularly pleased with the results they received.

In the west trainees are asked once or twice a year to provide feedback on their trainers.

Trainees: All the trainees felt that they could raise any issues/ideas they had with any of their supervisors or consultants at any time as they are all approachable. Trainees at Forth Valley have the opportunity to complete anonymous consultant feedback which they prefer to giving any feedback during their Annual Review of Competence Progression (ARCP).

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

Trainers: n/a

All Trainees: n/a

3.13. Handover (R1.14)

Trainers: In the north consultants are present at most of the handovers, the ward round takes place shortly after the handover. In the east there is a handover proforma to follow and a 10-minute teaching session after the handover. The evening handover is trainee to trainee.

In the Royal Infirmary of Edinburgh (south east) there are 2 daily handovers, morning and evening. Consultants always attend the morning one and often the evening one too. There are 2 handovers in both the Victoria Infirmary, Kirkcaldy and the Western General Hospital in Edinburgh.

Across the west region handovers follow a checklist, some including learning opportunities from the day and a check to ensure that trainees are safe to travel home after a night shift. There is consultant presence at every morning handover and usually at the evening handover too.

Trainees: In the north due to their rostered start time consultants do not attend the morning handover so no feedback is provided unless trainees stay past the end of their shift time. If the trainees do not stay this can lead to concern about whether or not information has been shared. The handover does not follow a specific structure. The evening handover which takes place at 1930 is usually attended by one of the newer consultants.

In the south east, the morning handover is always attended by a consultant. It follows a clear structure, is multi-disciplinary and is said to be robust. Trainees receive feedback at the handover and can also get some workplace based assessments completed too.

In the east attendance at handover depends which consultant is on duty so the handover tends to be trainee to trainee. It does follow a structure.

In the west region all sites have a structured handover process that usually follows a checklist. The morning handover is always attended by a consultant and the evening handover usually is too.

3.14. Educational Resources (R1.19)

Trainers: In all regions trainees have access to computers although it is recognised that the quality of these machines is variable. However, in Glasgow Royal Infirmary there are no dedicated PCs for trainees for non clinical work. Trainees in the north use the university Wi-Fi.

Trainees: None of trainees on the east coast had any major concerns about the IT facilities available to them apart from that there could be more computers made available to them and the connection quality/speed was not great.

Trainees who had worked in Glasgow Royal Infirmary said that access to a PC for non-clinical reasons such as audit or e-portfolio is tricky.

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

Trainers: Trainees in the south east have access to welfare guardians as well as a peer support network which is run by the anaesthetics department. There are no issues with accommodating any less than full time trainees.

Trainees in the east can speak to any of the consultant team should they need support. Training is discussed at consultant meetings and staff are aware of the Deanery support that is available particularly when dealing with doctors in difficulty. There is a new support network available for staff who have been through a traumatic experience at work. It can be difficult to accommodate less than full time trainees but working with the trainee to achieve a compromise works well.

In the north trainees are encouraged to speak to any of the consultant team. The department is now undertaking a reflective practice process which is particularly useful after a traumatic event.

Trainees in the west are encouraged to raise any concerns they have with any consultant. Any serious issues are escalated up the line to educational supervisors then to the Deanery if necessary.

Trainees: All the trainees felt well supported with one trainee saying that the ICM staff are even supportive with issues that took place in another specialty. Support mechanisms which have been well established in anaesthetics are now making their way to ICM. The east region have introduced wellness representatives.

In the west everyone is said to be supportive and helpful. A trainee who has worked less than full time have found the ICM departments to be supportive of their working pattern.

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: Staff in the north meet the associate director of medical education regularly and attend specialty training committee (STC) meetings. In the south-east staff attend the NHS Lothian faculty of clinical educators. They also meet with the associate postgraduate dean and attend the STC. In the East staff meet at the annual review of competence progression (ARCP). In the west educational leads from each department are invited to attend board educational governance meetings every 3-4 months. There are also regular STC meetings.

Trainees: In the north the trainee lead links in with the associate director of medical education and a dual trainee may join the anaesthetics STC.

In the east the anaesthetics trainee representative at the STC raises any ICM specific issues.

In the south east the ICM trainee representative asks trainees for feedback.

In the west there are trainee representatives on the hospital based governance meetings as well as the STC.

3.17 Raising concerns (R1.1, 2.7)

Trainers: Trainees in the east and north can raise concerns at the weekly M&M meetings. Morbidity is now also discussed at handover in the east. The south east also has weekly M&M meetings and anyone can submit an item to discussion. In some hospitals in the west they operate a suggestion box to submit any concerns (or positive events) and these are discussed at the morning safety brief. Any informal concerns can be raised with any of the consultants.

Trainees: In the east a safety dashboard checklist is completed after the morning handover. Anything from the checklist is discussed at the M&M meeting and where necessary an action plan is produced.

In the south east, a safety brief takes places in the morning and evening. Any urgent issues can also be raised with the safety lead. Representatives from ICM attend other departmental M&M meetings to learn from any incidents that have taken place involving multiple departments. These meetings are said to be learning experiences rather than a critical environment.

In the north there is a morning safety huddle and joint M&M meetings with Dr Grays Hospital in Elgin to discuss any issues that may have occurred during the transfer process.

In the west any critical incidents are discussed at the weekly ICM meeting as well as M&M meetings which trainees attend.

3.18 Patient safety (R1.2)

Trainers: Staff in all regions feel that their departments are safe and encourage trainees to raise any concerns that they might have.

Trainees: All the trainees would be happy for a friend or relative to be treated in their department as they feel it is a safe environment.

3.19 Adverse incidents (R1.3)

Trainers: In Fife there is an adverse incident suggestion box on the ward and Datix is also used. Following a recent incident in the west, the trainee involved said that they felt very supported. There is a no blame culture in the departments and the aim is to make it better for next time. There are hot and cold debriefs after an incident as well as Datix. Datix outcomes are shared in a learning bulletin sent to staff. Events are also discussed at M&M meetings and staff do occasionally attend other department's M&M meetings.

Trainees: In the north Datix is used to record any adverse incidents and management will feedback via an action plan.

Datix is also used in the south east and there is said to be increasing support available following incidents in the form of hot and then cold debriefs.

In the west incidents are recorded in Datix and discussed at the M&M meetings. In Forth Valley the minutes of these meetings are circulated round the department so that those staff who could not attend are aware of the outcomes.

3.20 Duty of candour (R1.4)

Trainers: Trainees in the north take part in the complaints procedure. In the east they are incorporated into adverse event discussions and in the south east the trainees are always supported, Whether or not they take part in discussions with patients' families depends on the trainees' wishes and stage of training. In the west there is a no blame culture around anything that could have been done better.

Trainees: In the east there is a culture of honesty and openness. When dealing with patients' families the consultants often lead the conversation to support the trainee but the trainee could lead if they wanted to.

In the north consultants are also said to be very supportive if something went wrong and would be very willing to speak to patients' families.

Trainees in the west have access to the duty of candour policy and feel well supported when speaking for families or if they were involved in an incident.

3.21 Culture & undermining (R3.3)

Trainers: The team in south east believe that the good consultant presence they have on the ward helps foster a team culture. In the north staff make sure that trainees know how to feed back if they feel they need to. Staff deal with any issues that arise on an ongoing basis and all staff are made aware that any bullying/undermining behaviours are not acceptable.

Trainees: Trainees in the north have in the past witnessed personality clashes between junior medical staff and nursing staff although this is said to be better than it was. In the south east and east none of the trainees had witnessed any undermining behaviours but would know how to escalate any issues if they did see anything.

Trainees in the west find their ICM colleagues very supportive. Handover can be challenging for more junior trainees however this is not said to be undermining. The TPD checks in with all trainees regularly to check that everything is ok with them.

3.22 Other

Trainees: Trainees in the east were concerned that under the new lead employer plans coming into force in August 2018 that they could be asked to cover rota gaps in another region.

In the west trainees were concerned that those are dual with ICM & Anaesthetics do not have enough knowledge to take on a ICM specialist consultant role unless undertaking a post CCT fellowship.

4. Summary

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

Both visits were very positive with a number of areas of good practice embedded in safe, good quality training environments.

The stage 2 requirements of ICM training cause logistical challenges in all regions. Until now this has been organised on an individual trainee basis using established links with anaesthetics in tertiary centres that take specialist patients from other hospitals for example Golden Jubilee Hospital. Trainee experience is personalised however the east programme noted that placements have been more difficult to negotiate for trainees who are not dual training with anaesthetics. The west programme noted that placements can be difficult to co-ordinate at times due to demand. This may increase if trainee numbers rise or if there is an increase in single stem ICM trainees or those dual with non-anaesthetic programmes.

It is noted that the clinical environment experienced at Stage 2 by the trainee can vary substantially throughout the regions. This is particularly so with the neurosciences and cardiothoracic subspecialties.

The stage 3 clinical experience to gain high level management skills also varies significantly. Trainees in the north and east stay on the one unit for the whole of the year. Trainees in the south east can be placed in the Victoria Hospital and/or Edinburgh Royal Infirmary. In the west trainees have 4x3 month rotations through QEUH, GRI and two other hospitals.

An issue highlighted at the visits for NES to take forward was that dual trainees struggle with the budget and time allocated through the study leave process as they require to cover a greater breadth of topics.

East Coast Visit

Positive aspects of the visit were:

- All regions demonstrated a supportive culture with excellent supervision and good communication at all levels.
- There was a strong patient safety culture with good examples of multi-disciplinary team working.
- All Consultants across the regions were described as supportive and approachable.
- All the regions are now linking in to the West of Scotland teaching programme.
- The south-east region runs a programme induction which includes trainees further on in the programme which is said to work well.
- The south-east region ICM staff link in with other departmental morbidity and mortality meetings in order to learn from incidents that have taken place.
- Trainees in the north region have specific programmed activity (SPA) time on their rota to work on things such as quality improvement projects.
- All Intensive Care departments were said to be supportive of trainees being released for study leave. Trainees in the east region also benefit from an endowments budget.

Areas that are working less well:

- Study leave budgets are restrictive in general and they appear to be handled differently in each region in terms of who approves financial reimbursement and how the budget is managed.
- There is no programme specific induction in the north & east regions.
- Handovers in the north & east regions can be unstructured with a lack of consultant and multi-disciplinary involvement.
- Trainees in the east region are not involved in referrals to the unit, particularly in the out of hours period.

West Coast Visit

Positive aspects of the visit were:

- There is a supportive culture across the region.
- The induction offered to trainees is bespoke and trainee centered outlining the whole of their training programme.
- The Institute of Neuroscience issues a letter to stage 2 trainees which clearly outlines what the department offers to trainees recognising their different training paths.
- The Regional Advisor and Training Programme Director (TPD) are said to be welcoming and supportive. Trainers appreciated the hard work of the TPD.
- Handovers across the region are structured with consultant presence.
- Forth Valley circulate the Morbidity & Mortality meeting minutes to all in the department so those that could not attend are aware of what was discussed.
- Trainees have easy access to study leave.
- The programme offers good training to become a general ICM consultant.
- Different coloured badges are being rolled to trainees across the region. The colours indicate which stage of training the trainees are at.

Areas that are working less well:

- We as a Deanery should note that dual trainees struggle with the budget and the time allocated through the study leave process as they require to cover more areas.
- There are not enough PCs in Glasgow Royal Infirmary for trainees to access for non-clinical work.
- Under the GMC's Recognition of Trainers requirements, consultants in Greater Glasgow & Clyde should have specified time in their job plans for trainee supervision.
- Placements for stage 2 trainees are difficult to co-ordinate at times and this may be more difficult if trainee numbers increase.
- The stage 3 4x3 month rotations are unpopular. Trainees do not feel that this is enough time in one place to undertake high level management training as they do not feel embedded within the units. It limits their ability to take part in any meaningful quality improvement work.
- Senior trainees perceived that the co-ordination with anaesthetics in terms of sub specialty ICM training is not as good as the general ICM training.

5. Areas of Good Practice

Ref	Item	Action
5.1	The south-east region runs a programme induction which includes trainees already in the department which is said to work well.	n/a
5.2	The south-east & west region staff link in with other departmental morbidity and mortality meetings in order to learn from incidents that have taken place.	n/a
5.3	Trainees in the north region have special programmed activity (SPA) time on their rota to work on things such as quality improvement projects.	n/a
5.4	The induction offered to trainees in the west region is bespoke and trainee centered outlining the whole of their training programme.	n/a
5.5	The Institute of Neuroscience in Glasgow issues a letter to stage 2 trainees which clearly outlines what the department offers to trainees recognising their different training paths.	n/a
5.6	Forth Valley circulate the Morbidity & Mortality meeting minutes to all in the department so those that could not attend are aware of what was discussed	n/a

6. Areas for Improvement

Ref	Item	Action
6.1	There is no programme specific induction in the north & east regions.	
6.2	The stage 3 4x3 monthly rotations are unpopular. Trainees do not feel that this is enough time in one place to undertake high level management training as they do not feel embedded within the units. It limits their ability to take part in any meaningful quality improvement work.	

7. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
7.1	Handovers in the north & east regions can be unstructured with a lack of consultant and multi-disciplinary involvement. (NHS Grampian & Tayside)	5 March 2019 – 9 months from date of visit	all
7.2	Trainees in the east region are not involved in referrals to the unit, particularly in the out of hours period. (NHS Tayside)	5 March 2019 – 9 months from date of visit	all
7.2	There are not enough PCs in Glasgow Royal Infirmary for trainees to access for non-clinical work. (NHS Greater Glasgow & Clyde)	5 March 2019 – 9 months from date of visit	all
7.3	Under the GMC's Recognition of Trainers requirements, consultants in GG&C should have specified time in their job plans for trainee supervision. (NHS Greater Glasgow & Clyde)	5 March 2019 – 9 months from date of visit	all