

Minutes and actions arising from the MDST (DME-Led Agenda) Meeting held at 10:00 am on Monday, 6th February 2023

Present: Emma Watson (EW) (Chair), Andrea Baker (ABaker) (Guest), Amanda Barber (AB), Ian Colquhoun (IC), Adrian Dalby (ADa), Alan Denison (ADe), Anne Dickson (ADi), Lindsay Donaldson (LD), Simon Edgar (SE), Matthew Gillespie (MG) (SCLF), Maximillian Groome (MG), Alice Harpur (AH) (SCLF), Adam Hill (AHi), Ian Hunter (IH), Katherine Jobling (KJ) (SCLF), Amjad Khan (AK), Nina MacKenzie (NMack) (SCLF), Clare McKenzie (CMck), Niall MacIntosh (NMacl), Alastair McLellan (AMcl), Lynne Meekison (LMeeK), Lesley Metcalf (LM), Kim Milne (KM), Michael Money Penny (MM) (Guest), Hugh Neill (HN), Colin Perry (CP), Karen Wilson (KW), Morwenna Wood (MW), Alan Young (AY)

Apologies: Peter Armstrong (PA), Helen Freeman (HF), Fiona Graham (FG), Olive Herlihy (OH), Christopher Isles (CI), David Kluth (DK), Neil MacLean (NMacl), Kate Patrick (KP), Jackie Taylor (JT), Anne Watson (AW), Pauline Wilson (PW)

In attendance: June Fraser (JF) (Minutes), Lisa Pearson (LP)

Item	Item Name	Discussion
1.	Welcome and Apologies from the Chair	The Chair welcomed all to the meeting, the group introduced themselves and apologies were noted as above.
2.	Declaration of AOB	<ul style="list-style-type: none"> Short Term Postponement to the Start of Training Programme - LM
3.	Simulation <ul style="list-style-type: none"> Sim Strategy and Funding presentation Resourcing/Plans going forward 	<p>Presentation given by ABaker and MM (copy of slides attached).</p> <p>Scotland's physical geography presents particular challenges to deliver high quality skills and simulation education, therefore more than 10 years ago, the Scottish Clinical Skill Strategy was launched and this was established to help address the inequity of access, the clinical skills managed educational network was formed to implement this strategy. This has a once for Scotland approach, with multi-professional, evidence based work and a realization of the importance of research and development whilst ensuring better value for money. One of the first pieces of work undertaken was to support a pilot for a bootcamp for surgical training in Inverness. 5 years later this is part of the IST curriculum. Within the strategy is the belief that no one should have to travel for more than 2 hours to access training.</p> <p>Over the years the network has amassed a number of frameworks, templates and national resources to support simulation based education and training. There are national standards with local ownership. The national framework has 3 tiers. The first 2 tiers are supported by online courses and there was agreement at the inaugural meeting held last month for the third tier to be developed together with the skill centre in Larbert, this will be a capability framework for SIM technicians.</p>

	<p>There is already a database of facilities and currently working on a database of the courses. There are 4 main delivery units – Surgical Skills Centre in Dundee, Scottish Centre for Simulation and Clinical Human Factors, Basics Charity Partner and the Mobile Skills Unit.</p> <p>There are now 16 APGDs for simulation covering 22 specialties (note of all on the slides). They were asked to come up with strategies for their specialties which have recently been received. Currently going through these to see if overlap/synergies for the courses and equipment they want to use.</p> <p>One of the challenges being faced is the allocation of APGDs (i.e. Higher Medical Training initially supposed to have 8 Pas allocated to it but now has 1). Another challenge is prioritisation as there will not be enough money to fund everything requested. It has been suggested that MDST will be the forum for decision making. The final challenge is faculty availability – particularly due to clinical pressures.</p> <p>It was noted by KW that currently sim work being carried out in NHS Grampian over 2 days on “Discharge without Delay”. NHS Grampian have been very enthusiastic about the work and it is thought that for behavioural change, simulation is probably the vehicle to deliver education.</p> <p>The chair summarised the issues coming out of the sim discussions as threefold:</p> <ul style="list-style-type: none">• Whilst there is an over-arching NES strategy there is variation across the specialties and stages as to how sim is used to support the curricula and also how this is funded and how faculty are supported.• Priorities are confusing at present.• Potentially the impact of simulation in IMT might be diluted due to current resource not being available. <p>The Chair requested that the group think about the significant investment from NES, Scottish Government and the Territorial Health Boards in simulation, and how everyone can work together to get best value and connection and what the themes and strategies should be going forward.</p> <p>The overall aim of strategy for simulation was discussed and it was requested that this be made clearer for all. Additionally discussed was how collaborative learning can be maintained when doctors are being requested to attend national bootcamps instead of learning locally.</p>
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4.	<p>Quality</p> <ul style="list-style-type: none"> • Update on Quality Calibration day • SMART Objectives • QRPs 	<ul style="list-style-type: none"> • Update on Quality Calibration Day – Recent Quality Calibration Day was an important stepping stone towards defining how improvement is supported. There were 2 prime elements – firstly, agreeing a flow chart for escalation and de-escalation from enhanced monitoring. A version has now been put together for discussion at the DQMG before being brought to MDST and DME groups. The second element was what support would look like for those cases which have been escalated to enhanced monitoring. The dimensions included are the support from the Healthboard, NES Quality, NES training management, MDST and Scottish Government. A document will be produced giving guidance on this.

		<ul style="list-style-type: none"> • SMART Objectives - KM shared some questions and queries which had come up from the DME group re the new SMART objectives. There is some confusion around the overall process and feel there are 2 systems almost running in parallel. The feedback was appreciated for the process, which is still being updated, however it was suggested that this may not be the correct forum for raising this sort of query. Quality are aware of some inconsistencies arising from the process and are committed to addressing these. It was requested that DME colleagues contact AH/AMcL/Jill Murray re any issues as and when they arise at the Quality/DME meetings. • QRPs – there was a calibration issue with some of the data for the DMEs as some of the same questions were asked. It was requested that the TPD enquiries could be shared with the DMEs so they can have a broader overview of what the other issues are. On the free text comments from the STS survey it would be helpful to know what Deanery action is, underway as this is often unclear. <p>AH noted that there had been some validation issues with the DME reports and the issues have been corrected for next year’s reports.</p> <p>AH also noted that there would be no problem to share the TPD enquiries with the DMEs. ADi and Jill Murray (Snr Quality Improvement Manager) will arrange a meeting with KM and any other DMEs who wish to discuss issues further.</p>
5.	Resourcing <ul style="list-style-type: none"> • Postgraduate DME role/QI within Board 	<p>Before moving to NES, LD had started gathering data around resources available in Boards to support the underpinning work done collaboratively with NES such as quality control, quality improvement and quality management on behalf of the GMC. The question initially asked of Boards was “Do you have enough resource in your Board to successfully undertake the Quality Improvement and Quality Control activities that are asked of you. Seven of the nine boards said “no”. When asked what would make a difference, items such as “resource to expand the DME office”, “an enhanced training quality lead quality funding stream”, “QI roles in boards to move forward action plans” and “support to increase number of PG Education roles” were put forward. The challenge that is faced is there is no explicit PG funding other than money for doctor and training salaries and a small amount of training quality lead money from 12 years ago.</p> <p>What Boards are finding overwhelming/unmanageable:</p> <ul style="list-style-type: none"> • Visits (some of which lead to re-visits) • Enquiries • Action plan monitoring and progression

		<p>Overall, it was felt that more resource required for:</p> <ul style="list-style-type: none"> • Activity linked to quality management • Own quality control • Efforts around joint quality improvement <p>The question was posed as to what information can DMEs provide which will be helpful to rebalance the resource into Boards to achieve this?</p> <p>It was noted there was a collective responsibility and suggested that a working group be put together with NES and DMEs, along with finance colleagues and STB chairs to look at the needs of the DMEs throughout Scotland. Some pilot work has been done in south east but need to look at the whole of Scotland.</p>
6.	Foundation Training Paper	<p>MW thanked the NES team for highlighting issues in Foundation Training via the NTS survey.</p> <p>A Foundation paper was circulated to the group from CMcK covering work done in conjunction with Foundation Directors and DMEs. It notes guidance and areas for improvement on educational leadership, ensuring that the foundation doctors feel like they belong and are being supported, and also ensuring they are growing from competent medical students into confident doctors. The paper has 3 phases and is currently in Phase 1. Discussion very much welcomed with CMcK, Associate Deans and Consortia Leads along with DMEs.</p> <p>It was noted from the NTS metric that do not fare well compared to the rest of the UK and are at the same time both the worst and the best performing area in Foundation in the UK.</p> <p>Commentary on the paper from DMEs/MDST member:</p> <ul style="list-style-type: none"> • Culture in surgical units is to support and train their registrars to be surgeons – need to extend this support into the Foundation layer. Issues with surgical job plans – under pressure with waiting lists and have little time in job plans to deliver support to foundation doctors onwards. • Transferring Surgical Learning to Medicine - much of the work in the surgical environment won't be applicable to Medicine. • IDLs are mentioned as taking up on 20% of the day however in reality this is greater. DMEs feel that F1s need to learn these skills as valuable learning opportunities for communication and time management.

		<ul style="list-style-type: none"> • The paper refers to having an F1 lead in each board – the issue is how to fund that. • Issue in translating the paper which is central for the whole of Scotland into how change designed and delivered at Foundation level within respective boards. Will depend on money/time/personal organization. • How can expectations be set for Foundation cohort that describe a positive working environment that will be developmental and where they will be respected and supported but also whilst getting work done? • If the Foundation doctors do not do the job (i.e. IDLs) then who will do it? Other staff also under pressure. • Jo Estland, Fellow in Edinburgh has come up with some excellent ideas for improvement and would be helpful to present these to NES either via MDST, at the conference or both. • Break taking and monitoring of rotas – are the biggest expectation challenge. • Setting expectations needs to be carried out at the beginning so trainees are aware of the differences between medical wards and surgery wards. • Strategies to minimise more complex IDLs would be worth pursuing, however most trainees are happy to deal with regular IDLS. • It would make a huge difference to the Foundation team if they felt there was a middle link to the senior tier. • The concept of ‘foundation jobs’ or ‘foundation tasks’ need to be eliminated and education needs to be prioritised with any tasks done in between. • It is not only foundation doctors who feel disenfranchised. Whole system approach using QI methodology needs to be applied. <p>It was agreed that Jo Estland could attend the Foundation Away Day and CMcK will contact Duncan Henderson to arrange this. All the other comments have been taken on board and can be discussed further.</p> <p>It was noted that breaks were part of a short life working group MSG/SJDC. ADi will contact the Chair and organise for DME representation.</p>
7.	Post Allocation Process for Uplift in Posts	<p>Paper 1 was circulated to the group – this has already been represented to the West of Scotland Regional Medical Workforce Group as it was a previous action from that group.</p> <p>Currently an uplift of an additional 152 posts across multiple specialties there has been collaboration with some TPD’s and none with others. It was felt there should be improved governance surrounding this. There are several time points prior to Transitions Group where can influence the numbers and there are in the STCs, STBs, MDST and Scottish Shape of Training Transitions Group.</p>

		<p>There is DME representation at each of these groups but it is recognized that it is difficult for a DME to represent individual Healthboards – they will be unaware of the detail of each board and their requirements/needs. Influencing around allocation can also take place once the allocation has been made either intra-regionally or inter-regionally. The recommendations of the paper asked that conversations take place between TPDS and DMEs and many of these are now under way. The final point in the recommendations is to design and undertake TPD inductions, away days and training that support everyone being aware of who is involved.</p> <p>It was asked if there is a document which describes what the principles are that govern the allocation of posts in general or the expansion posts. The Chair confirmed that NES are currently working with Scottish Government on this. There was also discussion on healthcare inequalities in relation to allocation.</p> <p>LD welcomes questions and comments on the paper and these can be emailed directly to her.</p>
8.	AOB	<p>Short Term Postponement to the Start of Training Programme</p> <p>Papers circulated are self-explanatory. Paper first discussed in November and reason for bringing back to MDST meeting is to garner DME comments. The team is looking for clarity on whether to continue to offer flexibility or is something else needed to replace the delayed start process from during COVID.</p> <p>Comments were:</p> <ul style="list-style-type: none"> • Concerned if went back to less flexible approach as other 3 nations are flexible. • Short extensions are fine as long as there is warning. • LTFT needs to be taken into consideration and a baseline allocation would be ideal to help going forward. • Work with IMGs should also be linked in to this. <p>DMEs are encouraged to contact LM directly with any further comments (Lesley.metcalfe@nhs.scot).</p> <p>It was noted that changes coming to Foundation allocation posts this year and the information will be cascaded to DMEs.</p> <p>MDST DME-Led Agenda Meetings</p> <p>The chair thanked the DMES for the conversations they brought forward to the meeting and requested everyone feeds back on what they thought went well in the meeting and what hasn't worked.</p>

Date of Next Meeting:

- **Monday, 6th March 2023 – 10:00-12:00 via Teams**
- **Next MDST with DME-led Agenda – Monday, 7th August 2023 – 10:00-12:30 via Teams**