

## GMC VISIT TO DEANERY REPORT

Please note: this report relates to the quality of specialty including GP education and training for doctors and does not comment on the quality of service and patient care provided

1. Postgraduate Deanery visited: North of Scotland	
2. Dates of visit: 12 – 15 July 2010	
3. Visit team	
	<b>Name</b>
Lead visitor	Gordon Mott
Visitor	Jeremy Heath
Visitor	Chandra Sekharan
Visitor	Jill Edwards
Visitor	Richard Antrobus
Visitor	Corinne Trim
Visitor	Phil Bunnell
GMC observer	Sarah Beattie
4. Training providers/trusts/hospitals/GP practices/NHS health boards visited NHS Grampian (Aberdeen Royal Infirmary), NHS Highland (Raigmore Hospital), NHS Orkney, NHS Shetland, NHS Western Isles (last 3 by Video Conference)	
5. Contact to whom the visit report is to be sent for factual accuracy check	
Deanery contact name(s)	Email address(es)
Professor Gillian Needham	<a href="mailto:Gillian.Needham@nes.scot.nhs.uk">Gillian.Needham@nes.scot.nhs.uk</a>
6. Existing reports referred to during the visit:	
<ul style="list-style-type: none"> <li>• Annual Deanery Reports to PMETB: 2007-2008; 2008-2009</li> <li>• PMETB evidence base, including surveys data</li> <li>• NES Annual Report 2008-2009 and corporate plan</li> <li>• Deanery monitoring visit reports and action plans for audit trails</li> <li>• NES QM Framework, and information on QM processes for Scotland at a pre-visit briefing combined with the East of Scotland Deanery.</li> <li>• TPD Annual reports for audit trail specialties</li> <li>• Annual Local Education Provider reports (NHS Grampian, NHS Highland)</li> <li>• The NES website</li> <li>• Other deanery documentation relating to quality management</li> </ul>	

## 7. Findings against GMC's generic standards for training

The visit team should identify notable practice as strengths of the provision, potential conditions as weaknesses and any actions that you consider essential or desirable under each of these domains. Each finding must be explicitly linked to evidence (either direct experience or from the evidence base presented).

### Domain 1: Patient safety

*The duties, working hours and supervision of trainees must be consistent with the delivery of high quality, safe patient care. There must be clear procedures to address immediately any concerns about patient safety arising from the training of doctors.*

D1.1 The visit team found a strong commitment to patient safety at the Deanery, and its involvement in and promotion of the Scottish Patient Safety Programme (SPSP) provides a good example of its commitment. The SPSP is a Scottish-wide programme which aims to improve the safety and reliability of healthcare across the country using evidence-based approaches, and this is being led on by one of the special Health Boards in Scotland, NHS Quality Improvement Scotland. A specific example of the implementation of this programme was the use of the Surgical Pause, the importance of which was cited by both trainees and trainers. The World Health Organisation (WHO) Surgical Safety Checklist initiative - a 19-point checklist of actions that should be taken by surgical teams to improve patient safety and outcomes, which has improved compliance with standards and decreased complications from surgery - in pilot hospitals is being piloted in hospitals within the North of Scotland Deanery. General surgery trainees confirmed the use of the WHO checklist. This includes the Surgical Pause at the beginning of all operations).

D1.2 All trainees interviewed stated that they were appropriately supervised and had good access to a consultant whenever required, and that consultants readily made themselves available. A trainee provided the visit team with an example of deanery responsiveness, that confirmed appropriate speed and action from the Deanery in situations concerning clinical supervision.

D1.3 Most trainees interviewed stated that they knew about local critical incident reporting systems (DATIX) and to whom to report any patient safety concerns, together with the importance of reporting such concerns promptly. Two GP trainees stated that they had used the critical incident reporting system and that this had led to changes in procedures. GP trainees also stated that they were given feedback on critical incidents and the action taken following an alert of this kind. Trainees consistently reported that handovers, consent procedures and rotas were appropriate and safe. At Aberdeen, the visit team was advised of a Clinical Governance Committee at board level which takes reports from the Departmental Clinical Governance Committees using DATIX.

D1.4 At Inverness, the visit team was told that a local survey of doctors in training showed that the doctors were under-using the critical incident reporting system because they felt it was a system for nurses. Consideration is currently being given by NHS Highland as to how to encourage the doctors to use the system. Patient safety issues are discussed at weekly surgical morbidity and mortality meetings in Inverness, and at training sessions.

D1.5 Trainees reported that induction, including aspects of patient safety, was significantly more mixed. Trainees stated that the issue of patient safety was well covered through GP induction and at Raigmore (Inverness), but was poor in accident and emergency (A&E) at Elgin. Trainees also reported a thorough induction process at A&E at Aberdeen, comprising a two-day programme. However induction in other placements was more varied and less thorough.

### Domain 2: Quality management, review and evaluation

*Specialty including GP training must be quality managed, reviewed and evaluated.*

D2.1 The Deanery has a well defined quality management (QM) policy and processes in line with

the GMC Quality Framework. The policy statement is clear and there are service level agreements (SLAs) with the five NHS Boards with which it works. The SLA is a thorough and clear specification of the roles, responsibilities and processes by which the Deanery and a local education provider (LEP) work together to ensure that postgraduate medical education and training is delivered in adherence to GMC standards.

D2.2 The Deanery uses a variety of instruments, including GMC trainee surveys, GMC trainer surveys, deanery surveys and visits to and self-assessment reports from LEPs. There is clear evidence of a QM cycle, whereby LEP self-assessment reports to the Deanery are considered and evaluated. The QM cycle is then secured through LEPs being asked, as necessary, to investigate issues further and report back to the Deanery on agreed time scales. This cycle is repeated until issues are resolved. The NHS Education for Scotland (NES) QM framework has been implemented following reviews, and the overall system is scrutinised and kept under review.

D2.3 The close structural and working relationships between the Deanery and LEPs mean that processes and initiatives are often operated on a partnership basis. The Deanery's system is very supportive to users at local level and perceived by users in this way, for example, in the establishment of Rural Fellowship programmes, through the Doctors in Difficulty programme and the provision of three deanery workshops a year for GP educational supervisors.

D2.4 The Director of Medical Education (DME) role in secondary care is new for Scotland and is acknowledged to be one that is in the process of development and is in the process of being embedded within the overall QM procedures. Senior staff at the LEP and Deanery welcomed the introduction of the DME role and recognised the potential benefits.

D2.5 The visit team found evidence that the Deanery flexes its systems in line with its judgement of local/individual circumstances. This is shown with GP trainers, where the Deanery has adopted a lighter touch monitoring by moving to a system of self-assessment every three years, balanced by annual appraisal of trainers and deanery trainer workshops, the results of the national training surveys and trainee post evaluation. This Deanery flexibility is also demonstrated in respect of trainees where, following trainee feedback, the Deanery has adjusted its deanery survey dates around the GMC survey to avoid trainee 'survey fatigue'.

D2.6 The Deanery is working with NES to develop end-of-placement evaluation to feed into the Pinnacle system. Because of the relatively small size of the Deanery, longitudinal evaluation of training schemes with small trainee numbers will need to be utilised to avoid identification of individuals.

### **Domain 3: Equality, diversity and opportunity**

*Specialty including GP training must be fair and based on principles of equality.*

D3.1 The Deanery has implemented a specific initiative to recruit lay persons and involve them in visits, committee work and annual review of competency progression (ARCP) interviews. This affords an additional opportunity to check on equality, diversity, and opportunity (EDO) matters. Lay visitors, who were part of a group of interviewees, were clear that they are empowered to check on matters such as possible harassment.

D3.2 All visits to LEPs encompass an EDO dimension, and EDO issues are covered in the training programme for those undertaking visits. The programme 'Same Difference' was advised as comprising part of this training. There is an ongoing programme of training for education supervisors and a parallel activity is due to begin with clinical supervisors.

D3.3 The Doctors in Difficulty provision is a secure and well organised one that would pick up EDO issues if they were the specific concern in a case, or formed part of a broader range of concerns. There is a strong emphasis on the importance of trainee feedback which has the capability of capturing EDO issues.

D3.4 The commitment of LEPs both to well developed relationships with the Deanery in general and to the partnership with particular regard to caring for doctors in training establishes a strong context for ensuring that EDO issues can be raised and addressed. Trainees were clear that when they had problems they knew to whom to turn. One trainee spoke positively of the Deanery's support to facilitate her return to less-than-full-time working and GP trainers referred to scenario-based training for EDO as part of the overall recruitment exercise.

D3.5 Trainees themselves seemed unaware of any formal EDO training within the overall provision made for them. The inclusion of such matters within the curriculum was mentioned but there was no reference to these issues being specifically addressed in their own right. However, they were confident about whom they might approach if there were problems.

#### **Domain 4: Recruitment, selection and appointment**

*Processes for recruitment, selection and appointment must be open, fair, and effective.*

D4.1 Recruitment is undertaken nationally within Scotland on an annual basis, with a follow-up exercise undertaken locally if required. The selection process works well, with trainees satisfied that it was a thorough, balanced and fair process. The process included a number of components which assessed different aspects of the applicant's overall experience and abilities and, taken in aggregate, were clearly felt to be fit for the intended purpose.

D4.2 With the exception of general surgery, there is lay involvement in the recruitment process and such persons receive training to allow them to discharge their role properly. Those involved in recruitment who come from within the Deanery or the LEPs have received appropriate training. Lay persons were provided with feedback forms with specific questions for them to answer but it is too soon for the Deanery to have responded to this data. The trainees themselves affirmed their satisfaction with and confidence in the recruitment process that they had experienced. There were neither any negative observations nor any reservations expressed about the open and fair nature of the exercise.

D4.3 The view was expressed that, overall, the national (Scotland-wide) system militates against the interests of a Deanery which encompasses remote and rural areas. Currently, it is felt that an area such as the North of Scotland is not, from the perspective of applicants, a favoured one to which to apply. The Deanery has instigated specific initiatives to promote its advantages and raise its profile, and is seeking to do more. The Deanery and its partners have common ground in believing that there would be merit in considering a Scottish rural-track GPST programme, which would then allow for the listing of well-marketed, well-constructed rural-track rotations within the options provided for trainee recruitment.

D4.4 Overseas doctors are recruited under the Medical Training Initiative scheme, particularly in paediatrics and surgery. They are treated in a similar fashion to those on training schemes and are assessed by the ARCP process.

#### **Domain 5: Delivery of approved curriculum including assessment**

*The requirements set out in the approved curriculum must be delivered and assessed.*

*The approved assessment system must be fit for purpose.*

D5.1 Neurology training has recently been implemented as a national programme and there is a recognition that QM across the deaneries for this and other national programmes is currently work in progress, as each of the deaneries visit programmes varies. Neurology has not yet been visited as a national programme as the Deanery feels it needs time to embed. Neurology trainees reported feeling supported by the Training Programme Director (TPD) and they had not experienced any difficulties in trainers finding time to complete assessments.

D5.2 All the interviewed trainees had undergone appropriate ARCP/RITA evaluations and felt that the process was well managed. All interviewed specialty trainees were present at their ARCP and received feedback, and this was particularly appreciated. Trainees reported that the completion of ARCPs for both neurology and general surgery are by face-to-face panel meetings. While this is additional to the process and does not influence the ARCP outcome, trainees were appreciative of these arrangements which they felt worked well and provided an opportunity to discuss career options and provide feedback on posts. All “non-Outcome 1” GP trainees routinely receive face-to-face ARCPs, but the Outcome 1 trainees do not, the total numbers being too great at 176 to allow for this; however, they were very positive about the educational supervisors’ review meetings.

D5.3 The Deanery’s GP team acknowledged that not all posts are ideal for delivery of the curriculum for historic reasons, for example, a shortfall in the number of paediatrics posts and over-provision of orthopaedics. A number of initiatives have been introduced to address these shortfalls: (a) a paediatric scholarship programme; (b) an educational programme which consists of 18-20 study sessions over the whole programme open to all trainees, with access through video-conferencing for “remote and rural” track trainees; (c) small group learning sessions, also accessible through Video Conference; and (d) TPDs will move trainees if a particular experience is required which can only be secured through a change in location.

D5.4 GP trainees were concerned about their experience within hospital placements meeting the needs of the curriculum, with a perception that some departments prioritised trainees in the specialty over GP trainees. Such variability was highlighted in the 2008-09 TPD annual reports. A&E was reported as being very supportive, holding regular training sessions which the GP trainees were encouraged to attend. The trainees stated that they are aware that the Deanery is actively pursuing a resolution of these concerns. The trainers informed the visit team that additional session times have been provided for GP associate advisers specifically to review clinical supervision within the hospital placements, and a clinical supervisor’s pack has been produced setting out the curriculum requirements. Another initiative is to take the Supporting Clinicians on Training - Scotland (SCOTS) courses out to remote and rural areas to overcome some issues of poor attendance at centrally run courses.

D5.5 The general surgery trainees felt that, with the implementation of the Working Time Regulation (WTR), the core surgery trainees have less operating experience and the senior trainees have an expectation that they will need to complete a fellowship in order to ensure that they have had sufficient experience for their consultant post. The TPD and trainers are aware of these issues. As part of the reconfiguration of services within Aberdeen, they will be reviewing their use of the separate acute and elective procedures blocks, to try further to maximise the operating and emergency medicine experience available for the junior trainees.

D5.6 Trainees recognised the value of the use of simulation to overcome some of these problems. However, they were also realistic about the limitations of such ‘surrogate’ opportunities. The opportunity to book the Suttie Centre facilities is open to all trainees, although use of the

facilities is currently adopted more by core trainees at present. The mobile clinical skills facility is used at Fort William and has been well received.

D5.7 There was recognition from the TPDs met by the team that not all trainers in secondary care had at this time been trained and that there was currently a lack of means of identifying where the gaps are at a Quality Control level. SCOTS training is generic; however, steps are being taken to make the necessary modifications for specific specialties.

### **Domain 6: Support and development of trainees, trainers and local faculty**

*Trainees must be supported to acquire the necessary skills and experience through induction, effective educational supervision, an appropriate workload, personal support and time to learn.*

D6.1 Induction was undertaken at both departmental and Board (organisational) levels. At remote settings, the specialty induction was provided by Video Conference.

D6.2 GP trainees universally reported a comprehensive induction to GP practices lasting several weeks and involving other members of the primary healthcare team. Induction in hospital posts was reported to be of variable quality; A&E induction in Inverness, lasting three weeks, was of particularly high value, that in Aberdeen was commended, but A&E in Elgin was poor. Induction at the Acute Medical Unit in Aberdeen was similarly unsatisfactory.

D6.2 All trainees had a named educational supervisor. The setting of aims and areas requiring focused training was identified early. Many GP trainees had the same educational supervisor for the entirety of their three-year programme, but those based initially in a more remote setting had a local educational supervisor for the first year.

D6.3 Learning e-portfolios were used by trainees in GP and surgery. GP trainers reported in-depth training at their residential training courses on how to use them effectively, including benchmarking to calibrate standards of the educational supervisor's report.

D6.4 Surgical trainees describe the ARCP process as being a positive one, particularly the face-to-face review. However, the geography of the Deanery made travelling to the review very time consuming for those not based in Aberdeen.

D6.5 The Deanery has a comprehensive careers support team, delivering seamless careers advice from undergraduate to specialty trainee level. Two members of the team had been supported by the Deanery to obtain a postgraduate certificate in careers support. The results from the Deanery's research study, *The Scottish Medical Careers Cohort Study*, was being used to inform operational decisions. Surgical trainees reported frequent, informal careers advice from their clinical supervisors, which was reinforced by educational supervisors and at the ARCP face-to-face meetings.

D6.6 Working patterns and work intensity were significant issues in all specialties seen, due to the WTR and failure to recruit fully. This had resulted in rota gaps and difficult working patterns in surgery and paediatrics; only two of the six GP ST posts on Orkney were filled at the time of the visit. This has been recognised by the Deanery and health boards, and the visit team was informed of reconfigurations that had been made and others that were planned to address these issues, for example, consultants resident on call, nurse practitioners, and the appointment of two academic fellows in surgery who will participate in the hospital-at-night rota in Inverness. The DME at NHS Highland is monitoring this situation and working with the Deanery and Health Boards to ensure that training standards are maintained.

D6.7 Clinical supervision was felt by the trainees and trainers in surgery and GP to be a strength in this Deanery (This was in contrast to the GMC trainee survey of 2009 which had red flags against clinical supervision in hospital posts for GP trainees). Very often the trainee is directly supervised by the consultant. Both GP trainers and surgical consultants were valued for the formative feedback they provided for their learners.

D6.8 Of the trainees in GP and surgery met by the visit team, there were no reports of behaviour that undermined their professional confidence or self-esteem.

D6.9 The Deanery's study leave policy was well known by all trainees, and additional funding has been made available to support the additional travel costs for those based in remote settings. Nevertheless, trainees reported that their study leave budget was inadequate to fund the courses they needed to attend. There are issues with the mismatch of the financial and academic years. Funding is available from August to August, but that not spent by the end of the financial year (March) cannot be carried over into the new financial year. Additionally, there are disproportionate allocations between ST1, ST2 and ST3 for GP. Financial allocation of study leave for each specialty is based on a notional allocation of £500 per post; the TPDs manage their specialty budget across the trainee year, i.e. August to July, and across the programme. This is the same for all Scottish Deaneries. The remaining budget after the TPD has covered delivery of the educational programme varies year by year, and therefore what the trainee has left to "draw on" from the budget each year appears different to them. Trainees also reported that it was difficult to take time for study leave due to tight rotas.

D6.10 There is no academic CCT training for GPs within the Deanery currently, but some examples do exist, post-CCT, such as rural GP fellowship posts. There has been a recent initiative in Inverness to develop surgical academic training to allow trainees to undertake training for an MD.

D6.11 The team noted several examples of the Deanery's approach to ensuring training for educational supervisors and clinical supervisors, including the SCOTS programme. This comprises three modules (clinical supervision, educational supervision and Doctors in Difficulty) and aims to deliver the standards required for trainers. In Inverness, there was an 80 per cent uptake among hospital educational supervisors. Although the Deanery was able to report the uptake of training for trainers across the Deanery, this information did not appear to be held in a form that allowed the information to be accessed by those at LEP level. An Associate Postgraduate Dean and Team are undertaking visits to deliver training at the more remote sites.

D6.12 All new GP trainers are selected for their role and undertake the national Scottish prospective trainer's course, four lots of two days' training followed by a two-day update course. More experienced trainers are expected to attend at least two out of three two-day residential courses. These courses ensure calibration and benchmarking of GP training standards across the Deanery.

D6.13 The Deanery has developed specialty tailored, clinical supervisors' packs to inform hospital clinical supervisors of the needs of the GP curriculum; however, these did not appear to be widely used.

D6.14 The hospital-based educational supervisors are not appraised for their role, apart from those at NHS Highland who are involved in the enhanced appraisal pilot as a part of the wider GMC revalidation project.

D6.15 The Rural GP Fellowship programme is designed to provide GP trainees with post-Certificate of Completion of Training (CCT) experience that focuses on attaining skills for rural practice (attached to one of: Orkney, Caithness, NW Sutherland, E Sutherland, Lochaber, Skye and Lochalsh) to equip them to excel in a similar environment post-training. One graduate of the rural track programme reported it as a good experience during which she had been fully supported, and two graduates of the rural surgical training programme have been appointed to consultant posts in relevant settings.

### **Domain 7: Management of education and training**

*Education and training must be planned and maintained through transparent processes which show who is responsible at each stage.*

D7.1 The Deanery has a clear management structure for the delivery of training and education. The Deanery has adapted and devised innovative ways of managing training programmes; this is necessitated by the geography of the region, which hosts hospitals in remote and rural areas.

D7.2 The development of rural GP training programmes and the use of Video Conferencing is a commendable practice. There is a good structure and management plan for the GP programmes, as is evidenced by the curriculum information pack 2010. GP educational supervisors undergo structured training before taking up this role. The clinical supervisors have a curriculum pack given to them to help in delivery of the programme and adherence to the GP curriculum. The GP trainees felt that they did not always get enough experience from hospital posts and that some clinical supervisors lacked awareness of the GP curricular requirements. The GP trainees felt that the placements, training and educational supervision while in the GP practices were excellent.

D7.3 The surgical trainees have a clear understanding of the roles of clinical and educational supervisors. The training programme provides good opportunities for trainees to meet the requirements of the surgical curriculum. One indicator of this is the excellent exam pass rates in the Deanery. The simulator training rooms provided opportunities for learning the basics of laparoscopic and other procedures like endoscopy. However, the trainees felt that this would need further development along with the acquisition of more modern equipment if it was to provide more advanced training. All the senior trainees said that they will need to do a post-completion of training fellowship before taking up consultant jobs to consolidate their surgical experience. All the specialty trainees were very appreciative of the support and supervision they received from the trainers.

D7.4 The neurology trainees reported positively about the wide range of clinical experience they were able to gain during their placements. They had good support and clinical supervision from the trainers.

D7.5 There are good relationships and reciprocal partnership arrangement between the Deanery, LEPs and other management groups involved in delivery of training. There are representatives of the Deanery on various committees in the LEPs. During meetings with the visit team it was evident that the personnel involved had a good rapport with each other.

D7.6 There is a robust process in place for dealing with Doctors in Difficulty in the Deanery and the LEP. There is an Associate Dean with responsibility for Doctors in Difficulty, who also leads for less-than-full-time training. One of the strengths of the system is the close working relationships between the Deanery and occupational health services; there are regular meetings between the consultant in occupational health and the Associate Postgraduate Dean for less-than-full-time training, which are reported to the Dean. Confidence in the occupational health clinicians has resulted in a greater than average number of referrals and early identification of

relevant issues. Customer satisfaction data and other monitoring data are routinely collected and provide evidence of how well the process works. Several trainees who have been through the process act as 'champions' to encourage others to engage with the service. Many trainees were not aware of this policy, but they had a clear knowledge with regard to whom to approach if a problem arises.

D7.7 The SCOTS programme is in place for training the educational supervisors in the clinical specialties. Currently, not all educational supervisors have completed this. The Deanery is aware of this omission and intends to address it. All the GP educational supervisors have finished a structured training programme before taking up their role and about 77 per cent of educational supervisors in other specialties have received training.

D7.8 Consultants at Aberdeen are encouraged to take up additional responsibilities such as College examiners or regional advisers. This was evident from talking to trainers, as two of them were undertaking such roles. Although there was tension between the competing priorities of delivery of service, maintaining targets, and training the juniors, the consultants had managed to resolve this by organising the operating lists in a different manner and even occasionally doing extra lists. In addition, the consultants, along with the LEP, are looking at supporting professional activity time and how this could be done as a team job plan.

### **Domain 8: Educational resources and capacity**

*The educational facilities, infrastructure and leadership must be adequate to deliver the curriculum.*

D8.1 The DMEs have recently been appointed to provide additional leadership for educational governance at LEP level. At the time of the visit, insufficient time had passed for there to be evidence of quality improvement resulting from the implementation of the DME role.

D8.2 In many of the departments sampled, the ratio of trainees to trainers was extremely favourable. Surgical trainees and trainers at Raigmore (Inverness) felt that they benefited from a single tier of middle grade. This provided more one-to-one training time with consultants. In rural locations, junior trainees commonly receive their clinical supervision directly from consultant colleagues.

D8.3 The visit team found surgical trainers highly responsive to the needs of trainees. Exposure to sufficient practical experiences is a concern generally in the craft specialties, due to the limitations imposed by the WTR and the New Deal. Trainers at Raigmore frequently rearrange elective cases on theatre lists and reorganise sessions of educational value to avoid clashes. Trainees felt that they benefited greatly from these interventions.

D8.4 The clinical skills centre at Inverness is well equipped with a wet lab and other facilities for simulation training. These facilities also serve undergraduates and foundation trainees, but there is sufficient capacity for specialty, including GP, trainees to gain equal access. A similar situation exists at the new Suttie Centre in Aberdeen, which also has the potential to provide postgraduate training.

D8.5 A mobile skills unit has been purchased as a Scottish national resource and is available for use in the Deanery. This allows trainees at rural hospitals to access equipment that would otherwise only be available at larger centres. Trainees are advised by email of the dates when this will be in their area and are able to take time to utilise this facility.

D8.6 In rural locations, educational facilities are less comprehensive; however, they are still

adequate in terms of access to the IT facilities, libraries and meeting rooms. Some GP trainers commented that their ability to deliver high quality training would be enhanced by more modern premises.

D8.7 Within the Deanery, there is extensive use of Video Conferencing to deliver teaching. The perception of trainees and trainers in urban areas is that Video Conference is a great educational resource which contributes significantly to the high quality of their educational experience. However, in rural areas, trainees are dependent on Video Conferencing for the delivery of elements of their core teaching and are therefore vulnerable to issues of technology reliability. Concerns were raised over the reliability of Video Conferencing at the following locations: Elgin (Dr Gray's), Wick (Caithness), Orkney and Shetland. Concerns have been raised formally by trainees, who have confidence in the Deanery to continue addressing, and thus improving, the issue of reliability. A specific deanery QM process for monitoring the reliability of this technology did not appear to be in place; however, the Deanery's QM processes had allowed for concerns to be raised.

D8.8 All GP trainers have protected time for training. However not all hospital consultants with an educational role have specific recognition of time for training in their job plans. The newly appointed DMEs in Inverness and Aberdeen are planning to address this. At Aberdeen, the visit team was told that job planning is reviewed/monitored by the general managers who use 'team plans' to support training. For general surgery it was stated that there was a genuine recognition of the time needed for training but this is difficult to operationalise and is dealt with differently at different LEPs. Neurology trainers stated that they did have time for training.

## **Domain 9: Outcomes**

*The impact of the standards must be tracked against trainee outcomes and clear linkages should be reflected in developing standards.*

D9.1 The Deanery publishes outcome data for ARCP and records of in-training assessment (RITA), and uses the Scottish educational database, Pinnacle, developed by NES to evaluate and follow trainees' progress. This tool has occasioned some cause for concern and is undergoing revision. Version 2, which will provide more reliable and comprehensive reporting, is soon to be released.

D9.2 The results of examinations, including MRCS, FRCS, MRCP, FRCP, MRCGP, MRCPsych and the neurology exit examination were known to trainees and trainers. However, this information was often accessed from the examining bodies rather than from the Deanery, and benchmarking data was not always available. Trainees and trainers in general surgery enjoyed a particularly good success rate at the FRCS, which they believed was the best in the UK. GP trainers in Grampian similarly reported above average success rates in MRCGP, despite recruitment difficulties.

## **8. Findings against GMC's standards for deaneries**

*Each finding must be explicitly linked to evidence (either direct experience or from the evidence base presented).*

### **Standard 1: The postgraduate deanery must adhere to, and comply with, GMC standards and requirements**

S1.1 There is a QM team, a visit panel and a planned visits schedule to LEPs. This panel of visitors includes lay members who have a two-day induction programme and other planned training. Nursing staff are involved during the visits. The Deanery carries out a process for considering and acting on the reports, and there is a fully functional system to ensure completion

of this process.

S1.2 The previous visits undertaken by the QM team looked at overall QM issues. The QM team is currently undertaking programme-based visits which focus on individual training programmes and ensuring that training programmes are compliant with GMC standards.

S1.3 Educational governance is incorporated into the Deanery's documents and NES Scotland has a management structure in place for its delivery.

S1.4 The recent appointment of two DMEs (with further substantive appointments to be made) is part of the overall plan for ensuring delivery of QM in the Deanery. It is the intention of the DMEs that they will in due course ensure the training of the educational and clinical supervisors, in addition to securing specialty programme delivery according to GMC standards for postgraduate education.

S1.5 There is interaction between the QM team in the Deanery, LEPs and the governance committees in the LEPs.

S1.6 The establishment of a leadership and management project is part of the QM initiative. This is to help the trainees prepare for taking on GP and consultant roles and responsibilities.

## **Standard 2: The postgraduate deanery must articulate clearly the rights and responsibilities of the trainees**

S2.1 The Deanery has recently established the Specialty Trainee Advisory Group (STAG). This forum allows trainee representatives across the range of specialties to communicate issues of proper concern to the Deanery. Patient safety is a standing item on the agenda, and the informal climate in which meetings are held ensures openness and freedom of expression for trainees. The STAG also allows the Deanery to cascade down information to trainees. An example of the Deanery using this effectively is in communicating the responsibility for trainees to participate in the QM processes, such as the GMC survey and visit.

S2.2 The Deanery utilises the ARCP/RITA process to encourage participation in surveys. Efforts have been made to raise awareness of the need for trainees to complete the GMC survey in order to increase the response rate. The Deanery indicated that their response rate for the 2010 GMC national survey of trainees, as they understood it at the time of the visit, is over 90 per cent., compared with 79.4 per cent in the previous year.

S2.3 Advice and support are widely available to trainees. The Deanery provides careers advice through a bespoke careers team which takes an overall active and supportive role. Additionally, specific support has been made available to trainees with regard to interview preparation. Support to trainees in difficulty is an area of particular strength, which builds on the close relationship between the Deanery and occupational health services.

S2.4 The Deanery recognises that trainees in smaller specialties may have more difficulty in raising concerns or accessing support. The Deanery has responded to this by establishing means for trainees to provide peer support to one another, for example, through a forum for trainees across pathological specialties. There is also informal communication between some associate deans and trainees in smaller specialties to ensure that any issues are promptly identified.

**Standard 3: The postgraduate deanery must have structures and processes that enable the GMC standards to be demonstrated for all training and trainees within the sphere of their responsibility**

S3.1 The Deanery has appropriate structures and processes in place. However, as a number of appointments are recent (for example, DMEs), as is the revised QM Framework, the overall effectiveness may take a while to assess. The two recently appointed DMEs stated that they are just starting to develop links as a team and review structures for working across the North of Scotland. A Scottish-wide DME Group and Medical Directors Group are in place. There is also a North of Scotland Medical Directors Group.

S3.2 DMEs and TPDs are members of the Deanery's QM group and DMEs are responsible for feeding back to LEPs and following up on action plans. DMEs are involved in the appointment of TPDs. A potential conflict of interest was noted in neurology, where the DME (NHS Grampian) and national TPD were the same person.

S3.3 The TPDs and DMEs felt supported by the Deanery, both formally and informally, with administrative support for TPDs provided by specialty training officers. The DMEs are about to appoint training quality leads to provide additional LEP support for TPDs.

Educational supervisors reported that they also felt supported by the Deanery and receive feedback from surveys.

S3.4 The visit team considered that the team-based approach to supporting training with QM visits encompassing multi-disciplinary feedback was positive.

S3.5 NES has established seven Specialty Training Boards (STBs), with a wide membership including the medical Royal Colleges. The visit team questioned the size of the potential membership of the STBs, specifically for medicine covering so many specialties, and the Deanery felt that the support of a Liaison Dean as a member is beneficial. The STBs have a role to play in the QM Framework.

S3.6 The visit team considered that the process the Deanery has introduced for trainees in difficulty is an excellent package, offering support for the trainee from the TPD and from an associate dean for the LEP. There was evidence of wide partnership engagement, specifically with careers management.

S3.7 The visit team found that there is an informal open policy for contacting the Deanery, assisted by the close proximity of the deanery offices, LEPs and the universities at Aberdeen and Inverness. The CEO at Aberdeen was very positive about the good working relationships, with formal structures in place whereby the Dean sits on a number of health board committees, including the Staff Governance Committee. However, at a meeting with trainees, their perception was that the Deanery officers seemed powerless to influence change at a health board.

S3.8 In order to assist with sharing notable practice, there is an educational supervisors forum, four GP trainers groups, and an annual conference. It is planned that members of the senior management team from the health boards should be involved in the QM visits panels in future.

S3.9 There is a lack of clarity amongst trainees with regard to an individual trainee's continuity of service when moving between NHS providers. Where a trainee is required as part of the programme arrangements to rotate from one employer (Health Board or GP Practice) to another, current arrangements require that one contract ends and another begins. This is a national issue

that is recognised and being addressed by NES in partnership with the Scottish Government's Management Support Group, the NHS territorial Boards and the BMA.

**Standard 4: The postgraduate deanery must have a system for use of external advisers**

S4.1 External medical advisers are involved in some areas of the Deanery's processes. A surgical Specialty Advisory Committee (SAC) representative, from without Scotland, attends the surgical ARCP panels in Aberdeen. A Royal College of General Practitioners external adviser is involved in part of the ARCP process for GP trainees.

S4.2 Ten lay advisers were appointed in 2009. They are involved in several of the Deanery's QM processes. The advisers met by the visit team appeared very well trained and aware of the benefits they contributed to the QM systems with which they were involved (for example, ARCP panels, deanery visits). They saw their role as one whereby they could impartially scrutinise the processes in which they participated. They felt that their particular standing allowed them to ask questions and seek information which helped ensure that trainees were well served and standards maintained.

**Standard 5: The postgraduate deanery must work effectively with others**

S5.1 The Deanery is part of an interlocking set of arrangements within NES, which seek to secure the ongoing provision and quality of postgraduate medical education and training. The Deanery encompasses five territorial boards, each of which has its Chief Executive and Executive Medical Director. An overall NES Medical Directorate comprises a central management team, one of whose standing committees is a Medical Directorate Quality Management Group. The NES Medical Directorate includes the four postgraduate deaneries, one of which is the North of Scotland Deanery. Additionally, there are seven specialty training boards which work with the deaneries to deliver postgraduate training. There is a liaison postgraduate dean for each specialty training board. The specialty training boards' essential remit is to support NES and the deaneries in commissioning and delivering specialty training. The North of Scotland Dean is the liaison dean for the specialty training board in mental health specialties.

S5.2 The North of Scotland Deanery is based at the Foresterhill campus and is co-located with the University of Aberdeen Medical School and the Royal Aberdeen Teaching Hospitals on the largest hospital site in Western Europe. It also has offices within the campus of the Raigmore hospital in Inverness.

S5.3 The Deanery has worked hard to secure strong relationships with those organisations with which it works. In this it is significantly assisted by the co-location of the Deanery with the hospital and university premises cited above. However, such geographical proximity is a useful but not sufficient condition to secure and maintain the professional collaborative linkages between the matrix of individuals and organisations summarised in S5.1. The evidence provided to the visit team, orally and in writing, has demonstrated that professional relationships and joint working are of a high order. In large part this is because the Dean has led her team in ensuring that the Deanery operates in monitoring, supporting and listening modes, and by so doing secures an appropriate reciprocity.

S5.4 The visit team was presented with a range of practical ways in which the partnerships operated. The careers team stated that they were keen to support the work of the Deanery and presented themselves as a valuable resource for trainees. The deanery visit teams to LEPs report back to the Deanery's QM group from where issues arising are dealt with through established

internal procedures. The deanery team has established good relationships with clinical supervisors to jointly address the 'Red Flag' issues. There is a link with the health boards to facilitate consideration of clinically significant events and feed back findings. The role of DMEs has recently been established and some substantive appointments made. The intention is that DMEs, who are appointed by the health boards, will receive deanery management reports and participate in visits, and this is a developing component of the partnership. The Deanery is working with Aberdeen University on web-based delivery of the General Surgery tutorial programme on which feedback is reported as positive. The senior team from NHS Grampian spoke of well developed relationships with the Deanery and commended the leadership provided by the Dean who serves on a number of committees, including the Service Strategy Development Committee and the Performance Reference Group. Similarly, there are Grampian representatives on the Deanery's QM group and involved in the Deanery's QM visits. The North of Scotland Deanery is the host deanery for national neurology training and responsible for the co-ordination of education and training across all four deaneries. It has not been possible to determine the details of this arrangement but the visit team was told that issues raised with the North of Scotland Deanery were then advised to the relevant local deanery.

## Summary

### Strengths

1. Trainees, trainers and deanery staff showed high awareness of and commitment to patient safety practices. The SPSP initiative demonstrates awareness and prioritisation of patient safety. (paras D1.1, D1.2, D1.3, D1.4)
2. Good responsiveness by the Deanery to feedback from trainees and its partner organisations. (paras D1.2, D2.3, D2.5, D3.4, S2.2)
3. A well defined quality management system, with a clear cycle, good range of supporting mechanisms, and review of GP practice visits, all providing a good basis on which to develop further their QM processes. (paras D2.1, D2.2, D2.5)
4. A well regarded Doctors in Difficulty programme, particularly in linking to careers support and occupational health. (paras D2.3, D3.3, D6.5, D7.6, S2.3, S3.6)
5. Strong support for training of "remote and rural" trainees. Innovative ways to address the challenges presented by such settings have been developed, such as the mobile clinical skills unit, the video-conferencing facilities, delivery of SCOTS courses in remote and rural settings and development of rural surgical fellowships. (paras D4.3, D5.6, D6.11, D7.1, D7.2, D8.4)
6. The provision of simulation resources at the Suttie Centre and the clinical skills centre at Raigmore, both of which are capable of being developed as valuable facilities for specialty training. (paras D5.6, D8.4)
7. Good relationships and reciprocal partnership arrangements between the Deanery, LEPs and other management groups involved in the delivery of training. (paras D7.5, S5.3, S5.4)
8. Multi-disciplinary approach to quality management visits. (paras S1.1, S3.4)

### Areas for Improvement

1. Induction is variable across specialties. (paras D1.5, D6.1)
2. Trainees seemed unaware of any formal EDO training (D3.6).
3. The lack of lay involvement in the recruitment to General Surgery training programmes(D4.2).
4. Variability in the delivery of the curriculum of GP trainees within secondary care placements, with a perception that some departments prioritised specialist trainees. (para D5.4, 6.12, 7.2)
5. Perceived effect of WTR on operating experience available to Core Surgery trainees. (para

- D5.5)
6. Not all educational supervisors have undertaken training for their educational role. (D5.7, D6.11)
  7. There are inadequacies in recording and sharing data, such as EDO and training of trainers, between the Deanery and those at QC level. (paras D5.7, D6.11, D7.7)
  8. There are limited academic training opportunities available to trainees. (D6.6)
  9. There are concerns over the reliability of video conferencing for the delivery of training, and of the Deanery-based processes in place for monitoring this. (para D8.7)
  10. Not all hospital consultants with an educational role have specific recognition of time for training in their job plans. (D8.8)
  11. There is a lack of clarity with regard to the continuity of service for GP trainees when moving between NHS providers. (S3.9)

### Signature of Lead Visitor



**Date** 29 September 2010

### Decision of VTD Panel

#### The provision at North of Scotland Deanery has:

Met with conditions the standards and requirements of GMC

#### Notable Practice:

1. Innovative ways to address the challenges presented by remote and rural settings have been developed, and strong support exists for trainees training in these settings.

#### Conditions:

1. The Deanery must ensure that all educational supervisors have been trained for their educational role.
2. The Deanery must review the departmental induction arrangements to achieve consistency and assure patient safety.

#### Recommendations:

1. The Deanery should take steps to ensure that all clinical supervisors of GP trainees in hospital posts are familiar with their curriculum requirements.

Signature of Chair of VTD Panel

Jane Rein

Date 29 September 2010