

# **Combined Quality Assurance of the Foundation Programme and Specialty Training**

Report on West of Scotland

July 2010

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# Introduction

1. The General Medical Council (GMC) and the Postgraduate Medical Education and Training Board (PMETB) had different but complementary legal responsibilities to regulate Foundation Programme training. The GMC set and maintained standards and outcomes for Foundation Year One (F1) and PMETB set and maintained standards for Foundation Year Two (F2)<sup>1</sup>. Since merger in April 2010 the GMC holds responsibility for setting and maintaining standards across the continuum of medical education.

2. In March 2007 the GMC Education Committee and PMETB Training Committee and Board agreed the *Standards for Training for the Foundation Programme*. The PMETB *Generic Standards for Training* were adopted with two additional specific standards for the foundation programme where necessary to reflect the requirements in this period of training.

3. The GMC and PMETB piloted the Quality Assurance of the Foundation Programme (QAFP) process extensively from 2005 to 2007 and the first round of live visits were undertaken in 2007-08. In March 2007 the GMC and PMETB published joint *Standards for Training for the Foundation Programme* and agreed Outcomes for F1 which were published by the GMC. The standards and outcomes were published together for the first time in *The New Doctor* in 2009. The current cycle of QAFP visits completes in November 2010 although monitoring of the outcomes of visits will continue into 2011.

4. The visited deanery is required to complete a self assessment and submit policies, procedures and data relating to their quality management of education and training to the GMC and PMETB. This data is then analysed by the visit team who create an action plan on the basis of this information mapped against the *Standards for Training for the Foundation Programme*. This action plan outlines what the team wish to explore during the visit and is shared with the deanery in advance of the visit.

5. PMETB introduced the Quality Framework (QF) in December 2007, the QF is a single overarching framework linking quality-assurance activities together. It places emphasis on deanery quality management and specialty input at local and national level. Visits to Deaneries (VTD) are one of the interrelated elements of the QF.

6. At its meeting of 4 February 2010, the Postgraduate Board recommend that Council adopt the revised *Quality Framework* including changes to reflect the transfer of responsibilities to the GMC. The Council agreed on 16 February 2010 and the Quality Framework continues until the end of its current cycle at the end of 2010.

7. The GMC and PMETB agreed to combine the scheduled QAFP and VTD visits to the South East Scotland, West of Scotland and Defence deaneries to reduce the burden of visiting and pilot methods of combined quality assurance to inform

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<sup>1</sup> This statement is subject to legal advice as the Foundation Programme is not mentioned explicitly in legislation.

regulation of medical education following the merger of PMETB into the GMC and the completion of the QAFP and QF cycles in 2010.

8. This report will be presented to the GMC Postgraduate Board.

### **Background to visit**

9. The West of Scotland deanery (known hereafter as “the deanery”) is responsible for 2879 trainees including 780 foundation doctors, 231 anaesthetics, 113 general surgery and 23 Ear, Nose and Throat (ENT) trainees.

10. The visiting team met with members of the NHS Education for Scotland (NES) management team on 19 April 2010.

11. The visiting team met with members of the deanery management team on 20 April 2010.

12. The visit team conducted visits to three hospital sites within the West of Scotland: Royal Alexandra Hospital, NHS Greater Glasgow and Clyde on 21 April 2010 and Crosshouse Hospital, NHS Ayrshire and Arran and Dumfries and Galloway Royal Infirmary, NHS Dumfries and Galloway on 22 April 2010. During these visits the team met with members of the local faculty and trainees doctors at each site.

13. The visiting team held a wrap-up meeting with the deanery management team on 25 May 2010.

14. In May 2010 the report of the visit was sent to the deanery to confirm factual accuracy. The factual corrections and timescales for the deanery to respond to the conditions and recommendations in the report were agreed at the wrap up meeting on 25 May 2010.

### **The team**

15. The visiting team members appointed by the GMC (and PMETB) to undertake the quality assurance visits were:

Dr Steve Ball (Team Leader)  
Dr Terry McMurray (Deputy)  
Dr Ted Adams  
Dr Catherine Dickinson  
Mr Adrian Drake-Lee  
Dr Carol Griffiths  
Dr Chris Hands  
Mrs Jane Nicholson

16. Jennifer Barron and Sarah Beattie (GMC Education Quality) supported the team.

# The report

## Summary of our key findings

17. The team consider that subject to the implementation of the conditions in this report the deanery meet the standards for delivering the foundation programme and specialty training.

18. The team and the deanery have agreed that the deanery will provide a plan to meet the conditions and recommendations within three months and an audit of implementation for condition 32 within six months and the remaining conditions and recommendations within nine months of the GMC Postgraduate Board's endorsement of this report.

### Notable practice

19. This section of the report draws together areas of deanery notable practice identified through the visit and in this report.

20. The team were impressed by the deanery's red, amber, green analysis of trainee survey data by unit and the subsequent follow up of both positive and negative outliers (see paragraphs 59, 77, 93).

21. The team were pleased to note the deanery's clear process for monitoring the outcomes of visits and ensuring improvements are made to the quality of training where mandatory recommendations are identified (see paragraph 94).

22. The team commend the Doctors Online Training System (DOTS) which was devised within the deanery and has been extended across Scotland at foundation level, it is an excellent training resource and monitoring tool (see paragraph 98).

23. The team commend the deanery for its work supporting refugee doctors to gain GMC registration and enter foundation and specialty training within the UK (see paragraph 114).

24. The team commend the collaborative approach to shadowing and the creation of a common shadowing week directly before the beginning of F1 (see paragraph 142).

25. The team commend the collaborative and facilitative role of the deanery in the joint organisation of the Preparation for Practice block in the University of Glasgow MB ChB programme (see paragraph 143).

26. The team commend the widespread enthusiasm for and universal access to audit projects in both Foundation and Specialty programmes (see paragraph 161).

27. The team were impressed by the provision of and access to clinical simulation within the deanery and across Scotland (see paragraph 180).

28. The team commend the recruitment, selection, training and appraisal processes in place for lay advisors (see paragraph 196).

#### Conditions

29. To meet the standards for delivering the foundation and specialty including general practice (GP) training, the team has identified the following conditions.

30. The deanery must work with NES colleagues to ensure that arrangements for effective transfer of appropriate information within the statutory framework exist:

- a. between local medical schools and the deanery and
- b. between placements within the foundation programme (see paragraphs 62-65).

31. The deanery must work with NES colleagues to ensure local education providers (LEPs) are given timely information about unfilled posts to ensure they can undertake local recruitment (see paragraph 120).

32. The deanery must work with the Scotland Foundation School to put in place a systematic approach to allocation of F2 to ensure it is open and fair (see paragraph 123).

33. The deanery must submit the results of its project to map the foundation curriculum to the posts within each foundation programme and details of programme changes as a result (see paragraph 127).

34. The deanery must work with the TPD in Anaesthetics to ensure that trainees' programmes equitably afford them the opportunity to cover the curriculum and gain the competences within it (see paragraph 129).

35. The deanery must work with NES colleagues to ensure that educational supervisors have been appropriately trained to undertake assessments (see paragraph 131-133).

36. The deanery must work with the Scotland Foundation School to ensure that consistent standards are applied for sign off at the end of F1 and F2 (see paragraph 141).

37. The deanery must ensure that appropriate educational handover occurs for all trainees (see paragraphs 147-150).

38. The deanery must work with the Scotland Foundation School to review educational supervision of foundation doctors and the role of the Foundation Training Programme Directors (FTPDs) in monitoring foundation doctors to ensure an appropriate longitudinal view is taken of their progress (see paragraphs 152-153).

39. The deanery must develop their strategy for the delivery of careers advice (see paragraphs 155-157).

40. The deanery must work with NES colleagues to ensure that an appropriate study leave strategy and an adequate budget are in place to support courses which are requirements of the specialty curricula, within the Scotland wide framework (see paragraphs 159-160).

41. The deanery must provide monitoring data to show that all trainers are appropriately trained for their role (see paragraphs 166-169).

42. The deanery must work with LEPs to ensure that standards of educational facilities are of a minimum standard and that they are secure (see paragraph 178).

43. The deanery must work with NES colleagues to further develop its use of external advisors in the verification that standards are being attained by trainees and in scrutinising the assessment process (see paragraphs 197-198).

#### Recommendations

44. To enhance the quality of the deanery's quality management, the team has identified the following recommendations.

45. The deanery should work with Training Programme Directors (TPDs) and LEPs to ensure robust transfer of information regarding doctors in difficulty between those responsible for education and service (see paragraphs 66 - 69).

46. The deanery should liaise with TPDs to ensure that only those who have been signed off at the end of F2 enter specialty including general practice training (see paragraph 72).

47. The deanery should extend DOTS to trainees of all grades where a similar mechanism, such as the Inter-Collegiate Surgical Curriculum Project (ISCP), is not already in use (see paragraph 98, 145).

48. The deanery should work with the administrators of the e-portfolio to ensure post assessment questionnaire (PAQ) data is released to FTPDs within an agreed and useful time (see paragraph 99).

49. The deanery should use resources such as the Medical Directors' consultant database and the trainers' email addresses provided in the Directors of Medical Education annual report to maintain a register of those providing educational supervision and to improve the response rate to the trainer survey (see paragraph 103, 107).

50. The deanery should work with forum members to ensure the outcomes of forum meetings and their existence are disseminated to trainees and local faculty (see paragraph 105).

51. The deanery should work with FTPDs to ensure its standard for attendance at core curriculum teaching is applied consistently (see paragraph 140).

52. The deanery should consider allowing F1s to borrow study leave from F2 to undertake a taster before application to specialty training (see paragraph 158).
53. The deanery should continue to support the DMEs to ensure that education is an important element of LEP business (see paragraph 199).
54. The deanery should work with lay advisors and central NES to ensure meaningful involvement and engagement of patients (see paragraph 200).

## 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.*

### Clinical Supervision

55. The NES requirements of clinical supervisors in specialty and GP training are clearly set out in *Quality Management of Postgraduate Medical Education and Training in Scotland*.

56. Clinical supervisors must understand their responsibilities for patient safety, be fully trained in the specific area of clinical care, teaching, providing feedback, assessing trainees and in equality and diversity best practice. They must also offer a level of supervision necessary to the competences and experience of the trainee and tailored for the individual trainee, ensure trainees are not required to work beyond their competency and only work without direct supervision once their supervisor is satisfied that they are competent to do so.

57. It is the responsibility of TPDs to ensure clinical supervisors are trained in carrying out workplace based assessments.

58. Foundation doctors are clinically supervised by the consultant under whose care the patient they are treating has been admitted, the clinical team and the duty consultant. In most cases their educational supervisor will also be a member of the clinical team in each placement (see paragraphs 147, 148, 152, 153).

59. Clinical supervision is monitored by the deanery through its QM programme: red, amber, green analysis of the national survey of trainee doctors (known hereafter as 'the trainee survey'), deanery quality management visits, foundation PAQs, LEP annual reports submitted by DMEs and Annual TPD reports.

60. Trainees of all levels, interviewed during the visit identified clinical supervision as appropriate and indicated that they were well supported.

61. The team did however hear of cross-cover arrangements between a psychiatric hospital and adjacent acute hospital where F2 doctors undertook psychiatric assessments at night with consultant support by telephone. The team were initially concerned that this could pose a risk to patient and trainee safety and advised the deanery using the GMC policy for raising concerns during a visit. The postgraduate dean responded positively and swiftly to provide the team with an interim report during the visit. An F2 doctor undertaking the psychiatric assessment would have received a half day induction to psychiatry, a half day induction with a consultant psychiatrist, a full day of teaching on managing aggressive patients and two days of training in psychiatric interviewing techniques. They would also be accompanied by a senior psychiatric nurse at all times. When making an

assessment of a patient the F2 would complete a structured proforma and contact the on-call consultant for a final decision regarding the management of the patient. The postgraduate dean is content that there is no risk to patient or trainee safety and there is no clinical requirement for an F2 to be involved in the psychiatric assessment that could be undertaken by a psychiatric nurse. The postgraduate dean has therefore undertaken to complete an assessment of the educational value of the cross cover arrangements and report to the GMC by 4 June 2010.

#### Foundation doctors' fitness to practise and transfer of information

62. The deanery receives transfer of information forms from UK medical schools using the UKFPO template, these are of a varying level of detail and the team heard reports that although foundation doctors were encouraged by their medical school to complete them however as they were not mandatory many would choose not to. The team did not hear of additional reporting mechanisms between the local medical school and the deanery.

63. Educational supervisors and FTPDs advised the team that a number of foundation doctors in difficulty had also experienced difficulties at medical school which were not declared or were not made known to them. Without prior notification they had not been able to put in place appropriate support for these foundation doctors at the beginning of their programme. This issue has been identified across the UK and the process is being reviewed by GMC and the Medical Schools Council.

64. There are no formal arrangements for transfer of information regarding foundation doctors' fitness to practise between placements within acute hospital settings or when foundation doctors moved into community placements. The national e-portfolio affords greater opportunity for clinical supervisors to review foundation doctors' performance in previous placements. However this is dependent on clinical supervisors' knowledge of and engagement with the e-portfolio.

65. While recognising the challenges of the existing Transfer of Information Process, and that there is a single Foundation School in Scotland that encompasses all five deaneries, the deanery must work with NES colleagues to ensure that appropriate transfer of information arrangements exist between local medical schools and the deanery and between placements within the foundation programme.

#### Support for trainee doctors

66. NES has a policy for the *Management of Doctors in Difficulty* ratified by the NES Medical Department Executive Team (MDET) and supported by the *NES Operational Framework: Postgraduate Medical Education in Scotland: Management of Trainee Doctors in Difficulty*. The framework outlines the responsibilities of clinical and educational supervisors, identifying and classifying problems, when the problem should be dealt with locally, require further investigation and should be referred to the deanery, their employer, their graduating medical school in the case of F1 doctors or the GMC.

67. The team found an awareness of both the policy and the framework. The application of the policy was less consistent. The team heard a number of examples

of support being provided for trainees and funding for a supernumerary post being provided by an LEP when the deanery was unable to; however the team also heard that transfer of information from one supervisor to another and between the educationalists and service providers could be improved.

68. The deanery also identified this as an issue in the 2010 Annual Deanery Report (ADR) to PMETB and its associated action plan. The deanery has recently provided funding for the introduction of associate/deputy Directors of Medical Education or Training Quality Leads within each of the five territorial health boards within the West of Scotland which may help to bridge the gap. The liaison between TPDs and the DMEs or their deputies will be key to the success of this.

69. The deanery should work with TPDs and LEPs to ensure robust transfer of information regarding doctors in difficulty between supervisors and between those responsible for education and service.

#### F1 and F2 Sign off

70. Progress by foundation doctors is monitored via continuous workplace based assessment and recorded on the e-portfolio. This is reviewed by their FTPDs before sign off at the end of F1 and F2. Educational supervisors, deanery foundation staff and LEP administrative staff also have access to the e-portfolio.

71. FTPDs interviewed by the team were aware of the requirements for and their role in sign off of foundation doctors. FTPDs normally meet their cohort of foundation doctors at the beginning and end of each year. The team are concerned that foundation doctors' educational supervisors will normally change every four months and FTPD meetings are not frequent enough to ensure an appropriate longitudinal view of foundation doctors' progress is taken before the point of sign off (see paragraphs 152, 153).

72. At the point of application to specialty including general practice training foundation doctors must produce a certificate stating that they are likely to be signed off at the end of F2 however the team heard that this was not always checked at the point a trainee entered a specialty training programme. The deanery should liaise with TPDs to ensure that only those who have been signed off at the end of F2 enter specialty including general practice training.

#### Working within Competency

73. The deanery issues guidance that it is the clinical supervisors' responsibility to ensure that trainees do not undertake tasks for which they have insufficient experience and expertise or perform tasks without direct supervision unless they deem the trainee competent to do so. The deanery monitors this through its QM programme.

74. The deanery provided the team with a case study showing that concerns raised via the national survey of trainee doctors around taking consent for procedures beyond trainee knowledge and competence and related indicators such as workload and work intensity were investigated during a deanery QM visit.

Concerns were partially substantiated following the visit and the unit in question received a copy of the report, took action to resolve issues including the drafting of new guidelines around specific procedures and the appropriate level of trainee involvement. The deanery continues to monitor LEP progress.

75. Trainees of all levels interviewed during the visit were content that they were not asked to work beyond their competence. The team are content that deanery processes are in place to address problems and that it is further developing its quality management processes to be more proactive and less reactive (see paragraph 96).

#### Needs of the Patients

76. The deanery ensures trainees make the needs of their patients their first concern through an organisation wide commitment to patient safety and public involvement, heavy emphasis during induction and monitoring via the deanery's QM programme (see paragraphs 200).

#### Consent

77. LEP and TPD annual reports require confirmation that all trainees are provided with clear guidance on taking consent. This is also addressed in the deanery's red, amber, green analysis of the trainee survey and if a potential problem is perceived will lead to a targeted visit or investigation by the relevant FTPD or TPD.

78. During the visit the team heard that trainees of all levels were taking appropriate consent. Anaesthetic trainees will undertake a three month orientation period before they are allowed to join a rota and work independently, training in taking appropriate consent is included in this extended induction period.

79. The deanery provided an example of investigating a concern raised by the trainee survey about inappropriate taking of consent (see paragraph 74).

#### Shift and on-call Patterns

80. At the time of visiting, central NES was in the latter stages of agreeing Service Level Agreements (SLAs) with the five territorial health boards within the West of Scotland. The draft SLAs include the LEP requirement to ensure compliance with Working Time Regulations (WTR).

81. Rota compliance at foundation level is delegated to FTPDs. Specialty Trainees are asked about WTR compliance during Annual Review of Competence (ARP) and Record of in Training Assessment (RITA) panels. Rota changes must be approved by the relevant associate dean. Monitoring exercises are undertaken by LEPs and, when requested, shared with the deanery.

82. The team heard from trainees of all levels that their rotas were WTR compliant on paper. However unfilled places on some rotas meant trainees were asked to undertake additional locum shifts and in order to be compliant some rota patterns necessitated a high proportion of time spent in out of hours work.

Anaesthetics trainees in one LEP were spending 50 per cent of their time working out of hours and general surgery trainees in one LEP regularly worked beyond the hours of their rota. A reduction in trainee numbers would leave such rotas unmanageable and impact on the quality of training.

83. Although working patterns did not impact on patient safety, trainees indicated a challenge attending core curriculum teaching and accessing study and annual leave because of rota patterns (see paragraph 162).

#### Patient Handover

84. When the deanery approves rotas they do not have to include a dedicated slot for patient handover but LEPs are encouraged to include an overlap between shifts when a handover could take place. Patient handover is included in departmental induction which is monitored via the deanery in the DME annual report and induction monitoring spreadsheets.

85. The deanery also monitors patient handover via the trainee survey and follow up visiting when it is asked as a matter of course as an element of clinical supervision.

## **Domain 2: Quality Management, Review and Evaluation**

*Postgraduate training must be quality managed locally by deaneries, working with others as appropriate, but within an overall delivery system for postgraduate medical education for which Deans are responsible.*

#### Roles, responsibilities and lines of accountability

86. There are four deaneries in Scotland, they are part of NES, a special health board which designs, commissions, quality assures and provides education for the staff of NHS Scotland.

87. NES has a multidisciplinary remit with a Medical Directorate. The MDET includes the Medical Director and Deputy Medical Director of NES and the four postgraduate deans. Many policy decisions are made by MDET and put into operation by the deaneries. The deanery is well supported by central NES with regular meetings driving innovations and sharing good practice across Scotland.

88. Where necessary for curriculum coverage, the deanery works with the other three deaneries to provide specialty training across geographical boundaries and training in a number of specialties is delivered nationally with one postgraduate dean taking the lead.

89. There are seven Specialty Training Boards (STBs) and a Foundation School Board which work at a Scotland-wide level. The boards are advisory and report to MDET.

90. There is one foundation school for Scotland with a School Director based in the North of Scotland, the associate dean for foundation regularly liaises with the Foundation School Director to ensure the deanery is compliant with Scotland-wide initiatives. The associate dean for foundation is supported by a number of FTPDs and consortia leads who co-ordinate foundation training within an LEP or group of LEPs.

91. Within the deanery there are Specialty Training Committees (STCs) for a specialty or a group of specialties. The STCs normally comprise a Chair appointed by the dean, a postgraduate dean or associate dean, educational supervisors, clinical directors, specialty trainees, royal college and academic representatives. The STCs' role is to support TPDs in delivering specialty training across the region. The TPDs interviewed during the visit considered deanery support to be good and welcomed the regular meetings of the TPD forum.

92. Four of the five territorial health boards within the geographical region of the deanery have recently appointed Directors of Medical Education; one board has had a DME in place for nine years. The DMEs were jointly appointed by the deanery and the service but are solely accountable to their Medical Director. The DMEs are champions of education and training within the boards and have been allocated resources by the deanery to appoint assistant/deputy DMEs or Training Quality Leads who are accountable both to the DME and the deanery. The relationship between the TPDs and DMEs will be important to the sharing of information and the delivery and quality control of education within the LEPs.

Identification, monitoring and resolution of issues and dissemination of outcomes

93. The deanery quality team, led by the Associate Dean for Quality and two Quality Improvement Managers take analysis of the trainee survey provided by central NES and further refine the data to give a red, amber, green analysis of units within LEPs taking into account responses from all levels of trainees e.g. a general medical unit would receive a collated analysis for its F1, F2, CMT and ST trainees. This would again be categorised red, amber and green by severity of indicator with matters of trainee and patient safety marked red for immediate investigation. Depending on the severity of the outliers the deanery will either trigger a visit or ask the appropriate TPD to investigate and report back within a specified timeframe.

94. Visits will normally be undertaken by two senior deanery members, a deanery QI Manager, FTPD or Foundation Consortium Lead if foundation is to be addressed, GP trainer if GP training posts are to be addressed, a specialty representative from the relevant STC or college and a lay representative. The quality team will send a targeted questionnaire to trainees and local faculty before the visit to ensure the views of the whole cohort can be considered and not just those working on the day of the visit. This is particularly useful when the cohort of trainees whose survey response generated an outlier have moved on to their next post. The team will normally meet trainees at levels within the unit, the Medical Director, Clinical Director, DME, TQL or Associate/Deputy DME and service managers.

95. Within 10 working days of the visit a report is produced indicating which of the outliers have been substantiated and the timelines for resolution of these issues. The

QI Managers then follow up on the mandatory recommendations throughout the year, LEPs are required to provide written updates supported by evidence to show that issues identified through the survey and subsequent visiting have been resolved. The Associate Dean for Quality will work with the QI Managers to ensure that actions taken by LEPs are appropriate and if not will put in place further mandatory recommendations or a re-visit if necessary. The team were pleased to note the deanery's clear process for monitoring the outcomes of visits and ensuring improvements are made to the quality of training where mandatory recommendations are identified.

96. The deanery makes good use of the data provided by the trainee survey but identified that its visiting programme was dependent on the survey as a single, though important, trigger. As a result the deanery is introducing a programme of rolling visits to LEPs that have not been visited as a result of outliers within the trainee survey.

97. The rolling programme of visits, although in its infancy, will allow the deanery to QM training in units with fewer than three trainees that are not reported on via the trainee survey and produce a more complete picture of education and training across the region as a whole.

98. In addition to red, amber and green analysis of the trainee survey and visiting the deanery collects quality data via the e-portfolio and DOTS. E-portfolio data includes numbers and outcomes of workplace based assessments and PAQs completed by foundation doctors at the end of each four month blocks. PAQs can be completed by other grades of trainee if they have access to the e-portfolio. DOTS data includes completion of induction and e-learning modules. The deanery is working to introduce PAQs with specialty specific items and for trainees who do not have access to the e-portfolio. DOTS is an excellent training resource and monitoring tool, the deanery should extend DOTS to trainees of all grades where a similar mechanism, such as the ISCP, is not already in use.

99. Foundation doctors complete PAQs via the e-portfolio and data collected includes: questions on induction, shadowing, the value of clinical experience and supervision, formal teaching, support from the team, access to educational resources including study leave and careers advice, intensity of training and whether or not trainees would recommend their job. Data are then fed back to the FTPDs who have responsibility for quality control of the foundation programmes under their direction. The team heard that FTPDs often did not receive this data in a timely fashion enabling them to resolve issues and inform the relevant cohort of foundation doctors. The deanery should work with the administrators of the e-portfolio to ensure PAQ data are released to FTPDs within an agreed and useful timescale.

100. The deanery also collects quality data via ARCP and RITA panels. Also through specialty e-portfolios including the ISCP. The deanery has committed to extending PAQs to specialty e-portfolios where practicable.

101. One area the deanery has identified for improvement is the provision of educational supervision, deanery monitoring of the numbers of educational supervisors and of the training they have received. All new educational supervisors

will be selected and must be trained for their role before they can commence supervision. However much educational supervision is provided by the goodwill of the consultant body. The deanery is keen to train current educational supervisors as well as incoming educational supervisors (see paragraphs 147-153).

102. The deanery requires LEPs to provide an annual report, normally completed by the DME, which includes: a list of training programmes supported by the LEP with an identified TPD; a list of key educators within the deanery including Deputy and Assistant DMEs; a self assessment of training provision and a self assessment of compliance with the *Generic Standards for Training*.

103. The deanery requires TPDs to provide an annual report, which includes: minutes of relevant training programme meetings; a list of trainees enrolled in the programme with details of their level and LEP; a list of LEPs contributing towards the programme with details of the responsible DME and lead educational supervisor; a list of educational supervisors and their email addresses; membership of the Specialty Training Programme Committee; a summary of trainee ARCP and RITA results; key findings from the trainee survey and college tutor responses; key findings from quality assurance (QA) and quality management (QM) visits by regulatory bodies and the deanery; an action plan to address issues arising from visits; a self assessment of compliance with the *Generic Standards for Training*. The deanery should use the trainers' email addresses provided in the DMEs annual report to maintain a register of those providing educational supervision and to improve the response rate to the trainer survey.

104. The deanery has identified the development of LEP quality control (QC) as a priority. As well as monitoring the LEPs' QC via the DMEs' annual report the deanery provides templates for the monitoring of induction, training of educational supervisors and mapping the foundation curriculum to posts within programmes. The deanery also provides money for Training Quality Leads or Associate/Deputy DMEs with a QC remit and facilitation and liaison between the STCs and LEPs.

105. The deanery receives feedback and evaluation on the quality of training by trainees via the foundation forum, PAQs, the specialty training forum, trainee representatives on some STCs and via the trainee survey. These forums were not widely known of at LEP level by local faculty or trainees and the deanery should work with forum members to ensure the outcomes of forum meetings and their existence are disseminated to trainees and local faculty.

106. The TPD Forum is a recently established and highly valued arena for TPDs to share experience and provide feedback to the deanery. The TPDs interviewed during the visit found the deanery to be accessible and supportive.

107. The deanery has found the trainer survey a less useful tool for informing its quality management due to the low response rate. The team met DMEs from the five health territorial health boards within the West of Scotland during the visit who considered they, together with the Medical Directors' consultant database, would be well placed to provide relevant contact details for those consultants with a remit for training foundation and specialty trainees which could increase the response rate. The GP Directorate of the deanery holds details of GP Trainers centrally.

## Quality Management and Quality Control of Post and Programmes

108. The deanery is currently undertaking a curriculum mapping project for the foundation programme. By consulting educational supervisors and foundation doctors the deanery is mapping the competences of the curriculum to the posts within each individual track to ensure that all foundation doctors gain the required competences before completing F1 and F2 (see paragraph 123).

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

*Postgraduate training must be fair and based on principles of equality.*

#### Equality and Diversity Data

109. Equality and diversity data are collected at the point of recruitment by the UKFPO at foundation level and NES at specialty including GP level. They are tracked across several years to identify trends in appointments but the team did not find evidence that equality and diversity data are linked to other areas relevant to training such as data on doctors in difficulty, bullying and harassment, ARCP and RITA outcomes or appeals (see paragraph 113).

#### Equality and Diversity Training Data

110. Foundation doctors are trained in equality, diversity and opportunity through DOTS, this allows the deanery to easily monitor which foundation doctors have and have not completed training.

111. Specialty including GP trainees are trained in equality, diversity and opportunity by their employing health board.

112. Educational supervisors with a role in recruitment will be trained in equality, diversity and opportunity by their employing health board. However the deanery has identified a gap and purchased licences for the online equality and diversity module *Same Difference* to be used by TPDs for their educational supervisors or trainees as necessary.

#### Quality Management and Outcomes

113. Equality and Diversity data are gathered largely around recruitment and are published on the NES website however the deanery does not currently use these data to feed into its quality management processes. Following discussions with the visiting team the Associate Postgraduate Dean for Foundation is going to liaise with administrators of the e-portfolio to link PAQ and equality and diversity data to identify trends and themes.

## Legislation

114. As part of NES the deanery is subject to the *Single Equality Scheme*. As such all policies and processes must meet the legislative requirement to promote equality of opportunity and eliminate discrimination and harassment on the grounds of race, gender or disability. The deanery must therefore assess the impact of their policies and processes on trainees and other stakeholders to ensure that no groups are unfairly advantaged or disadvantaged. Central NES has created a Rapid Equality Impact Assessment (RIA) Toolkit and a Full Equality Impact Assessment Toolkit (EQIA). The deanery has undertaken a number of RIA and EQIAs on its processes but the most comprehensive assessment the team saw looked at recruitment across Scotland. At the time of visiting the deanery had not been required to change policy or process as a result of an EQIA or RIA.

## Reasonable Adjustments

115. The deanery provided a number of case studies outlining the reasonable adjustments they had made to facilitate training for doctors in training with differing needs. These included doctors with disabilities who required specific equipment, extended training programmes, career breaks and less than full time training.

116. Where less than full time training was required the deanery would facilitate this if possible however the team heard that funding was not always available. DMEs were supportive in finding funding for less than full time training but indicated that with the current financial climate this would become more of a challenge. The deanery is beginning to look for alternative methods of providing less than full time training including slot sharing to reduce the reliance on supernumerary posts.

117. The deanery also runs a scheme to support refugee doctors to gain registration with the GMC and enter training programmes. This includes arrangement of clinical placements, support to organise English language lessons and testing, coaching for interviews and preparation for the professional linguistics assessment board (PLAB) exam. The team interviewed a number of doctors who spoke highly of the help and support provided to them by the deanery.

## **Domain 4: Recruitment, Selection and Appointment**

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

### Selection Procedures

118. Selection to the Scottish Foundation School is via the UKFPO. The deanery provides details of the posts and programmes to be recruited to and senior clinicians to undertake scoring of applications that have ranked Scotland as their first choice foundation school. Scorers will have training in the question they will be scoring. Appeals are lodged and administered via the UKFPO.

119. Recruitment to specialty training is via the Scottish Medical Training (SMT) website. The territorial health boards run selection and interview. The deanery is not directly involved but will support LEPs as necessary. Appeals are lodged and administered via SMT.

120. When posts remain unfilled following UK and Scotland wide recruitment they will be advertised via central NES and deanery websites. Applications are scrutinised by deanery staff and those deemed appropriate will be short-listed by two clinicians and interviewed by another two clinicians. Successful candidates will be ranked and matched according to their rank and preference to existing vacancies. If vacancies remain they are released to LEPs to fill. The team heard that LEPs were often given little notice when a post would remain empty leaving them without the opportunity to advertise and fill gaps. It was suggested that TPDs often knew of gaps considerably before LEPs, the communication of this may be improved by the deanery's appointment of TQLs and Associate/Deputy DMEs. The deanery must work with NES colleagues to ensure LEPs are given timely information about unfilled posts to ensure they can undertake local recruitment.

121. Currently LAT and trainees in these posts are supported by the deanery, their training is recognised and attracts study leave, the use of portfolios and other educational resources. While the team applauds the commitment to supporting these locum trainees this leads to recruitment difficulties for LEPs. The team heard that trainees appointed to programmes in hospitals as little as 30 miles from Glasgow will resign from their training post in order to take up a LAT in Glasgow. This causes gaps in harder to recruit to LEPs and little time to fill them. This was a particular problem at one LEP visited by the team which, although universally recommended by the trainees in post and considered by the deanery to provide a good quality of training, has difficulty attracting trainees due to its rural location.

### Selection Panels

122. Specialty training selection panels will normally consist of senior clinicians from the relevant STC who will be trained by LEP human resources departments for their role and in matters of equality, diversity and opportunity.

### Programme Choice

123. Foundation programmes are advertised via the UKFPO and NES website, once a foundation doctor is allocated to the Scottish Foundation School they rank their preference for foundation programme and based on their academic and application score are ranked. Programmes are then allocated based on preference to the top ranked applicant first. Depending on the F1 programme there will be a limited number of linked F2 programmes a foundation doctor can apply for. These are allocated on a preference basis as there is currently headroom in the system. The deanery advised that F1s will complete a form and where there is competition for a programme the national ranking for F1 or their e-portfolio will be used however the FTPDs and foundation doctors interviewed advised that there is currently no systematic process for allocation of F2, which varied according to FTPD This has largely worked so far because all incoming F2s have been accommodated with an F2 programme that has at least in part met their wishes. The deanery must work with

the Scotland Foundation School to put in place a systematic transparent approach to allocation of F2 to ensure it is open, fair and effective.

#### Appointments to Local Faculty

124. Appointments at TPD level and above are through open, competition with published job descriptions and person specifications. The team were less clear how appointments to STCs were made; these appear to be voluntary rather than competitive and not uniform across STCs.

125. Clinical and educational supervisors tend to volunteer rather than be appointed to their role. There is growing concern that the nine and one contract which requires consultants to provide 9 programmed activities (PAs) of service delivery and one of supporting professional activities will hinder new consultants from providing educational supervision. The team heard that some LEPs are choosing not to appoint to the nine and one contract or to appoint to a nine and two contract where consultants will provide educational supervision.

### **Domain 5: Delivery of Curriculum including assessment**

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

#### Programme description

126. Trainees of all levels interviewed during the visit considered there was adequate information regarding programmes on the NES and SMT website to allow them an informed decision when applying for specialty training. Anaesthetic trainees would welcome a continuation of this support as following ST1 there was less guidance provided on where training would be completed and some did not know which LEP they would be working in until shortly before changeover in August.

#### Practical Experience

127. The deanery is, as a pilot, the first deanery in Scotland to, with the aid of educational supervisors and foundation doctors, map the foundation curriculum to the posts within each foundation programme to ensure there is adequate practical experience and opportunity to gain the competences required. The deanery must submit the results of this mapping with details of programme changes as a result.

128. The deanery, working with the relevant royal college and faculty, submits posts and programmes to the GMC for approval. This includes whether or not posts and programmes will provide adequate experience and maximum training numbers that can be supported within the deanery.

129. The team heard that some anaesthetic specialty trainees moved across several LEPs in order to ensure curriculum coverage while others experienced a less varied case base when they stayed in the same LEP for up to four years. The deanery must work with the TPD in Anaesthetics to ensure that all trainees'

programmes afford them the opportunity to cover the curriculum and gain the competences within it.

#### Implementation of the Assessment System

130. At all three sites visited trainees of all levels were undertaking their WBAs and afforded the opportunity to sit specialty exams at the relevant stage within their training.

131. The team heard that educational supervisors were concerned by the tick box nature of WBAs and the significant time they were spending assessing trainees. Many educational supervisors had not received training in the use of e-portfolios and assessment tools which may affect the perception of their usefulness.

132. Some educational supervisors were cognisant that if used as a formative tool across a trainee's whole programme as well as a requirement for sign off, ARCP/RITA WBAs could be a useful tool to identify further learning needs and to identify doctors in difficulty.

133. Foundation doctors in all three LEPs advised the team that they were not receiving the comments from their multi-source feedback and educational supervisors confirmed that they were not aware of how to release these comments to foundation doctors. The deanery must work with NES colleagues to ensure that educational supervisors have been appropriately trained to undertake assessments (see paragraph 165-169).

#### Educational Documentation including Appraisal

134. Trainees at all levels had a named educational supervisor. Some found it harder to meet their educational supervisor at the beginning and end of a post and the quality of learning agreement was variable. Educational supervision at specialty training level appeared to be more effective, there is greater engagement with the tools for training and generally trainees remain with the educational supervisor for 12 months. Some foundation educational supervisors advised that they would train foundation doctors as though they were specialty trainees on a four month attachment and were not aware of the different e-portfolio requirements and learning agreements for the foundation programme.

135. Before ARCP/RITA trainees receive written advice from the deanery concerning the appropriate paperwork to submit. Foundation doctors are also provided with guidance regarding the requirements for sign off however there was some confusion regarding the requirement for Direct Observation of Procedural Skills (DOPS); the number required and for which procedures.

#### Feedback

136. Foundation doctors would like to be privy to the comments on their performance attached to the multi-source feedback (MSF). Some thought so little feedback was provided they could complete F1 or F2 without knowing whether or not they were a good doctor or whether they would be signed off.

137. Feedback to specialty trainees interviewed was generally considered to be better than at foundation level. The educational supervisors for specialty training have responsibility for their trainees over a 12 month period. However some trainees only had face to face ARCP/RITA every 24 months and would welcome greater feedback.

#### Good Medical Practice

138. Trainees of all levels interviewed during the visit were aware of the requirements of *Good Medical Practice* and had been provided with information regarding their duties as a doctor by the deanery.

#### Regular formal educational sessions

139. The team heard that trainees at all levels had difficulty being released for formal educational sessions and that these were often not bleep free. TPDs and FTPDs are working to ensure trainees can attend teaching by providing half and full day teaching rather than lunch hour teaching for F2 and above with sessions repeated up to three times to allow trainees to attend.

140. The team noted inconsistency in FTPDs interpretation of the deanery's requirement for foundation doctors to attend 70 per cent of teaching. Some foundation doctors and their FTPDs thought this was 70 per cent of all sessions while others thought they must attend 70 per cent of those sessions when they were not on nights, call or leave. The deanery should work with FTPDs to ensure its standard is applied consistently.

#### Suitability for Registration and Completion of the Foundation Programme

141. The team heard inconsistencies in the interpretation of requirements for sign off at the end of F1 and F2 regarding the number of workplace based assessments required and attendance at core curriculum teaching. The deanery must work with the Scotland Foundation School to ensure that consistent standards are applied for sign off.

### **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.*

*Support, training and effective supervision must be provided for trainee doctors*

*Support, training and effective oversight must be provided for local faculty*

## Shadowing

142. The deanery provides shadowing in the last week of July. This has been agreed and co-ordinated by the four of the Scottish medical schools<sup>2</sup> and the four postgraduate deaneries. This allows graduates from outside Scotland to attend as the Scottish Shadowing Week falls after other UK medical schools' graduation dates. The team commend this collaborative approach to shadowing and the creation of a common shadowing week directly before the beginning of F1.

143. The deanery has also been working with the University of Glasgow to assist in the delivery of a Preparation for Practice block in the final year. This includes six weeks working with an F1 doctor in the LEP where they will undertake F1 if staying within the West of Scotland and teaching around prescribing, advanced clinical skills, managing the acutely ill patient, life skills and ethics. The team commend the collaborative and facilitative role of the deanery in organising the Preparation for Practice block.

## Induction

144. Upon commencing training in the West of Scotland, foundation doctors receive a leaflet outlining the deanery's role and what they can expect of their deanery and their foundation programme. Specialty Trainees receive their National Training Number (NTN), a learning agreement and a registration form.

145. Some induction is delivered by DOTS, this allows the deanery to monitor whether trainees have completed elements of generic, hospital and departmental induction.

146. Where induction is not provided by DOTS the deanery requires the DME to submit a report in August, December and April each year confirming: what induction has been undertaken by each trainee; if anything is absent; the alternative arrangements the DME has made for that trainee. The deanery should consider extending DOTS to trainees of all levels where an equivalent such as ISCP is not in use.

## Educational Handover

147. Foundation doctors will normally have an educational supervisor for each four month block. Their educational supervisor will be a consultant or general practitioner in the unit where they are working. The deanery expects the educational supervisor to review the foundation doctors' previous assessments and supervisors' reports via the e-portfolio. However there is no formal handover process between supervisors and this leads to the significant risk that those Foundation doctors with educational needs are not identified in a timely manner.

148. The team heard that the educational supervisors' knowledge and use of the foundation e-portfolio was variable. Some educational supervisors found the e-

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<sup>2</sup> Aberdeen, Dundee, Edinburgh and Glasgow. The University of St Andrews also offers a three year BSc in medicine.

portfolio difficult to navigate and had not received training in its use. Foundation doctors and their educational supervisors advised that regular educational handover was not happening and only when a foundation doctor was experiencing difficulty would a handover, usually arranged by the FTPD, occur.

149. Specialty trainees will normally have an educational supervisor for a 12 month placement. Their educational supervisor will normally be a consultant in the unit where they are working. If the training programme is supported by an e-portfolio educational handover is expected to be by review of assessments and previous trainers' reports online. The team heard that this worked better via the ISCP in general surgery and ENT than at foundation level. However, the team heard that in anaesthetics LEPs often did not know which trainees would be arriving until the first Wednesday in August and that educational handover was not commonplace.

150. The deanery must ensure that appropriate educational handover occurs for all trainees.

#### Educational supervision

151. All trainees interviewed during the visit had a named educational supervisor and had all met their educational supervisor. Some found this easier to arrange and more useful than others depending on the varying levels of engagement by educational supervisors. The team found a greater enthusiasm for their role amongst the educational supervisors of specialty trainees.

152. Foundation doctors normally have a different educational supervisor for each four month post however at one LEP visited F1 doctors will have the same educational supervisor for 12 months. The team are concerned that educational handover is not robust and as FTPDs or Foundation Consortia Leads normally meet foundation doctors at the beginning and end of each year no longitudinal view of a foundation doctor's progress is taken.

153. The deanery must work with the Scotland Foundation School to review educational supervision of foundation doctors and the role of the FTPDs in monitoring foundation doctors to ensure an appropriate longitudinal view is taken of their progress.

#### Confidential Feedback

154. Provisions are made for trainees to feed back in confidence if they have concerns regarding their training (see paragraphs 189).

#### Careers Advice

155. Foundation doctors interviewed during the visit would approach their educational supervisor for careers advice and be referred to a consultant from the specialty they were considering. However, foundation doctors were not aware how to access support if they did know in which specialty they wanted to work. Awareness of the *Scottish Medical Careers Handbook* is poor.

156. The team also found little or no awareness of alternative career pathways or opportunities amongst the specialty trainees interviewed during the visit. Few had heard of SCREDS or knew how to access advice regarding changing specialties. Many of the specialty trainees interviewed by the team were highly motivated individuals who had created academic opportunities for themselves; all general surgery trainees interviewed at one LEP had or were in the process of getting a PhD.

157. The deanery must develop a strategy for the delivery of careers advice.

158. The team heard that tasters were available in F2 but most F2s interviewed had arranged a taster at a time after the deadline for application for specialty training. The deanery should consider allowing F1s to borrow study leave from F2 to undertake a taster before application to specialty training.

### Study Leave

159. The deanery's policy on study leave is widely disseminated and adhered to. Trainees did not generally have problems accessing study leave when rotas allowed time off. The deanery advised that study leave could be allocated to years of programmes on a needs basis to ensure trainees had adequate funds to undertake mandatory courses at the relevant time. However the team heard from surgical trainees that they had to self fund courses they considered to be mandatory.

160. The deanery must work with NES colleagues to ensure that an appropriate study leave strategy and an adequate budget are in place to support courses which are requirements of the specialty curricula, within the Scotland wide framework

### Audit

161. All trainees interviewed during the visit had participated in audit. The team commend the widespread enthusiasm for and universal access to audit.

### Working Patterns and Intensity of Work

162. Trainees interviewed during the visit all reported their rotas to be WTR compliant on paper. There was concern that rotas required a high proportion of out of hours work and that study and annual leave often had to be taken during weeks when trainees would have been working days thus skewing the balance of trainees' experience.

### Inter-professional Learning

163. The team heard that LEPs were encouraged to use multi-disciplinary team meetings as educational opportunities. Trainees advised that they often worked and learned with a variety of allied health professionals including nurses, advanced nurse practitioners, physiotherapists, midwives and pharmacists.

164. The multi-disciplinary remit of NES could lend itself to a coordinated approach to education and training at a strategic and delivery level.

## Support for local faculty

165. The deanery has identified development of local faculty as a priority and it is collecting data via TPD and LEP reports to identify gaps in training and support for local faculty.

166. Training is provided for trainers via Supporting Clinicians on Training in Scotland (SCOTS) courses. These are generic courses in managing the doctor in difficulty and clinical and educational supervision. Not all educational supervisors interviewed during the visit had attended a SCOTS course and of those who had, not all considered it to be useful. While recognising that such training is generic many would prefer an added component of foundation or specialty specific training, including in the curriculum, assessment tools and associated portfolios.

167. All educational supervisors interviewed had provision for educational supervision in their supporting professional activities (SPA) allowance although many did not consider they had enough time in their daily routine. There is no specific educational appraisal for local faculty below FTPD and TPD level.

168. Unlike clinical and educational supervisors, local faculty positions from college tutor upwards are subject to advertisement, interview and once appointed, appraisal.

169. The deanery must ensure that all trainers are appropriately trained for and have adequate time for their role.

## **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*

### Management Plans

170. The Scottish Government has overall and budgetary responsibility for medical education and training in Scotland.

171. The management plan for education and training in Scotland is set by NES, as a special health board of the Scottish Government, in *Quality Management of Postgraduate Medical Education and Training* and *The Governance of Postgraduate Medical Education and Training: The Arrangements in Scotland*. NES report annually to the Scottish Government, this report is published online.

172. Postgraduate medical education and training is managed and maintained by the deanery which is part of the medical directorate of NES. The unit of management is the training programme, the deanery has put in place a network of TPDs who hold responsibility for trainee allocation, programme management and QC. TPDs report to the deanery annually and are assisted in their role by deanery STCs and associate deans for their specialty or specialties. The TPDs liaise with LEPs to ensure training is delivered as required.

173. At the time of visiting central NES was in the process of negotiating draft SLAs with all health boards across Scotland. The SLAs will cover the responsibilities of NES and the LEPs in the delivery of undergraduate and postgraduate medical education and training in Scotland. This will include requirements for the monitoring and quality control of as well as delivery of training and specific legislative requirements such as equality and diversity and freedom of information.

#### Schedule of Responsibilities

174. The schedule of responsibilities for postgraduate medical education and training in Scotland are set out in *Quality Management of Postgraduate Medical Education and Training* and *The Governance of Postgraduate Medical Education and Training: The Arrangements in Scotland* (see paragraphs 86 - 92).

#### Identification, Support and Management of Trainees

175. The policy and process for identification, support and management of trainees whose conduct gives cause for concern is set out in the NES *Management of Doctors in Difficulty* ratified by the NES Medical Department Executive Team (MDET) and supported by the *NES Operational Framework: Postgraduate Medical Education in Scotland: Management of Trainee Doctors in Difficulty* (see paragraphs 66 - 69).

#### LEP Board Support for Education and Training

176. The newly appointed DMEs are not members of LEP boards but are Associate Medical Directors and seek to influence the board via the Medical Director. This role is therefore as a champion of education and training and influencing rather than holding the power to provoke operational change. The DMEs now have a direct route into clinical directorates and can take a greater interest in areas such as consultant job planning. DMEs would not expect to be involved in consultant job planning but can require clinical directors to provide evidence of the return they provide for the SPAs in job plans relating to educational supervision.

177. The likely reduction in trainee numbers across Scotland will necessitate liaison between the deanery and LEPs with the assistance of the regional workforce group. A reduction in numbers will impact on service, rotas and trainee experience. The TPDs and LEPs will have to work together to ensure that trainees are sent where they are needed but also where they can gain the competences required by their curricula. The deanery has identified that most LEPs outside of Glasgow receive a higher than proportionate ratio of junior to senior trainees. As trainee numbers reduce and the service responds, the deanery will need to work with TPDs to ensure this is appropriate.

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

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

## Regular Review of Learning Resources and Facilities

178. The deanery reviews learning resources via the trainee survey, PAQs and QM visiting. The team noted variability in the standard of educational facilities provided in the LEPs visited, most notably the absence of a safe and secure education centre at one LEP. The deanery must work with LEPs to ensure that standards of educational facilities are of a minimum standard and that they are secure.

### Ratio of trainers to trainees

179. The team heard that trainers would typically be responsible for no more than four trainees at any given time. This was considered to be manageable within the current allocation of SPA time to education.

### Clinical and practical skills labs

180. The team were impressed by the provision of clinical simulation within the deanery, feedback from all levels indicated the resources in the simulation centres in Stirling and Dundee were of a high quality and widely accessible. There is a central strategy and good local support for clinical simulation including some high quality simulation resources in individual boards, which will become increasingly important with the reduction in working hours, especially for craft specialties.

## Domain 9: Outcomes

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

*The outcomes for F1 and competences for the Foundation programme are published. All doctors should meet these outcomes and competences before successfully completing the Foundation Programme.*

181. The deanery tracks foundation outcomes by the number of foundation doctors not signed off at the end of F1 and F2, those requiring remedial support and numbers of referrals to the GMC. These outcomes are fed into the UKFPO Annual Report.

182. At specialty level the deanery tracks outcomes at RITA and ARCP. The deanery provides this information in the annex to the ADR. The deanery identified a need to track outcomes against performance in specialty exams and surgical exit exams and indicated in the 2009-10 ADR that this will be done via RITA/ARCP and through the use of e-portfolio.

183. Sharing of trainee outcomes will form part of the newly established relationship between the TPDs and DMEs and where specialty exam results are concerned, the deanery's external partnerships with the medical royal colleges, faculties and exam boards. The team note the deanery has good access to data via the ISCP.

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

184. The deanery is assisting LEPs to establish robust systems of quality control. It is also developing its QM framework to include a rolling programme of visits and regular collection of evidence via annual TPD and LEP reports. Thus moving away from sole reliance on the trainee survey to trigger quality activity.

185. Through the establishment of a Scotland wide group for QI Managers to share notable practice and other forms of collaborative working across programmes and deaneries the emphasis is shifting to include quality improvement as well as quality management.

186. The deanery has clearly mapped its QM framework to the published GMC standards and requirements for postgraduate medical education and training. The TPD and LEP annual reports include a self assessment against the *Generic Standards for Training*.

187. Educational governance in Scotland is decreed by central NES, the deanery's policies and process adhere to this and are in keeping with the principles of good regulation.

188. In January 2010, the deanery provided an ADR, annex of outcomes and associated action plan to PMETB for 2009-10 which were approved through a related element of the QF.

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

189. There are a number of routes for trainees to raise matters of concern. Those interviewed during the visit would most likely approach their clinical or educational supervisor or their TPD. There was some awareness of the trainee fora and of trainee representatives on STCs however this was not universal.

190. The deanery seeks prospective approval for all training posts and programmes and out of programme training and research posts through a related element of the QF.

191. The primary source of trainee input to the deanery's QM process is via the trainee survey. Trainees interviewed had all completed the trainee survey and kept their electronic receipt for this in anticipation that they would be asked to produce it for ARCP/RITA.

192. The deanery has yet to include trainees on QM visiting teams.

**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**

193. The deanery committee structure supports postgraduate training through a series of STCs for a specialty or group of specialties which act in an advisory capacity to the TPDs. They are complemented by a series of meetings by executive groups including the postgraduate dean and his associate deans which the newly appointed DMEs have been invited to attend and reported to be useful.

194. There is professional representation from royal colleges and faculties within the STCs however the team could not discern a common constitution or role across the STCs for college representatives.

195. Through input to the QI Managers Group and Scotland-wide STBs the deanery is afforded the opportunity to share and learn from notable practice.

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

196. The deanery via central NES and local recruitment has appointed a number of lay advisors. Following a central NES initiative, the lay advisors were interviewed and appointed by the deanery. They attended central and regional induction, which they found useful. The lay members who were met by the team were highly qualified and extremely motivated. They evinced a desire to involve themselves in the roles that the deanery had planned for their group. They were satisfied that the deanery had explained their roles fully and clearly. The team thought that the lay members could provide useful scrutiny of the deanery's processes. Lay members have completed their training and role familiarisation.

197. The team found little evidence of externality in RITA/ARCP panels beyond the observation of panels by local faculty within small specialties of larger specialties' ARCP. The team thought this a very good idea for sharing of experience but not evidence in itself of externality within the assessment process.

198. The deanery must work with NES colleagues to further develop its use of external advisors in the verification that standards are being attained by trainees and in scrutinising the assessment process.

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

199. The deanery is working well to create relationships with LEPs via the DMEs and TQLs or associate/deputy DMEs. However the DME role is mostly influential and the deanery should continue to support the DMEs to ensure that education is an important element of LEP business.

200. The team heard about the NES driven initiative patient focus, public involvement (PFPI) which seeks to ensure that NHS care is patient centred by including the views of the public at each stage of medical education and training.

PFPI is in its infancy and the deanery should work with NES and its lay advisors to ensure meaningful involvement and engagement of patients.

### **Acknowledgement**

201. The GMC would like to thank the West of Scotland Deanery and all those they met during the visits for their co-operation and willingness to share their learning and experiences.

## Annex A

### Glossary

ADR	Annual Deanery Report
ARCP	Annual Review of Competence Progression
CCT	Certificate of Completion of Training
DME	Director of Medical Education
DOPS	Direct Observation of Procedural Skills
DOTS	Doctors Online Training System
ENT	Ear, Nose and Throat Surgery, otolaryngology
EQIA	Equality Impact Assessment
F1	Foundation Year 1 Doctor
F2	Foundation Year 2 Doctor
FTPD	Foundation Training Programme Director
GMC	General Medical Council
GP	General Practice
ISCP	Inter-Collegiate Surgical Curriculum Project
LAT	Locum Appointment for Training
LEP	Local Education Provider
MDET	Medical Department Executive Team
MSF	Multi Source Feedback
NES	NHS Education for Scotland
NTN	National Training Number
PA	Programmed Activity
PAQ	Post Assessment Questionnaire
PFPI	Patient Focus, Public Involvement
PhD	Doctorate of Philosophy
PLAB	Professional Linguistic Assessment Board
PMETB	Postgraduate Medical Education and Training Board
QA	Quality Assurance
QAFP	Quality Assurance of the Foundation Programme
QC	Quality Control
QF	Quality Framework
QI	Quality Improvement
QM	Quality Management
RIA	Rapid Impact Assessment
RITA	Record of In Training Assessment
SCOTS	Supporting Clinicians on Training in Scotland
SLA	Service Level Agreement
SMT	Scottish Medical Training
SPA	Supporting Professional Activities
ST	Specialty Training
STB	Specialty Training Board
STC	Specialty Training Committee
TPD	Training Programme Director
TQL	Training Quality Lead
UK	United Kingdom
UKFPO	United Kingdom Foundation Programme Office
VTD	Visit to Deanery

WBA  
WTR

Workplace Based Assessment  
Working Time Regulations

West of Scotland Region

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AMcG/AR

3rd August 2010

Dr Jenkins  
Standards and Ethics Reference Group  
General Medical Council  
Regent's Place  
350 Euston Road  
LONDON  
NW1 3JN

Dear Dr Jenkins

### **Response from West of Scotland Deanery to GMC Visit Report 2010**

Thank you for the report of the GMC visit to the West of Scotland Deanery in April 2010 and for the opportunity to respond to it.

We experienced, in pilot form, a new style of visit which covered both Foundation and Specialty Training, supported by a new hybrid self-assessment document. We believe that the process which we experienced - the combination of a detailed and evidenced self-assessment triangulated against the findings of a well-coordinated and focussed visit team - is that which is most likely to prove a valid means of accurate overall assessment in the future. We would particularly commend the analysis of the self-assessment document and subsequent pre-visit enquiry; the pre-visit identification of matters for exploration during the visit; the opportunity for agreement over how these should best be evidenced and the final opportunity for evidence-based adjustment to errors within the draft report.

We were very pleased by the number of areas of notable practice which you highlighted. We accept the conditions and recommendations made by the GMC. These are in broad concurrence with our own analysis, which had shaped the development of work already underway. We undertake to meet the timelines for responding to you.

We would like to commend the visit team on their professional and courteous approach to their task and to thank the staff of the GMC for the invaluable assistance which they provided during the preparation for the visit.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Alastair McGowan'. The signature is written in a cursive style.

Professor Alastair McGowan OBE  
Dean of Postgraduate Medicine

