National review of medical education and training in Scotland: 2017–18

Working with doctors Working for patients

General Medical Council

Introduction

This report gives an overview of medical education and training across Scotland in 2017–18, aligned with the themes set out in *Promoting excellence: standards for medical education and training*. The findings are from our visits to eight territorial health boards, five medical schools and the Scotland Deanery.

Why did we choose Scotland?

As part of our quality assurance framework, we visit organisations that commission, manage, and deliver education and training within the UK. We do this to check that the standards outlined in *Promoting excellence* are being met. We have a schedule of visits (pdf) that covers each region and country within the UK.* We visited Scotland in 2017 as part of this schedule.

What do we know about Scotland?

NHS Scotland consists of 14 territorial health boards, and seven special health boards. As part of our national review of Scotland we visited eight territorial boards, as well as NHS Education for Scotland (NES), which is a special health board, and the five Scottish medical schools.

NES is an education and training body, with responsibility for developing and delivering education and training for the healthcare workforce in Scotland. NES has a Scotland-wide role in undergraduate, postgraduate and continuing professional development. There are approximately 5,600 doctors in training across Scotland.

The Scotland Deanery is the medical directorate within NES, and is responsible for managing postgraduate medical training and training programmes across Scotland. The deanery was created on 1 April 2014 from the four previous regional deaneries in Scotland. This review was therefore the first opportunity to visit Scotland as a single deanery.

There are five medical schools across Scotland. All except St. Andrews are approved to award a UK primary medical qualification.

University of Aberdeen School of Medicine

Medicine has been taught at the university since the founding of King's College in 1495. The school is based in the Suttie Centre for Teaching & Learning on the Foresterhill campus in Aberdeen and in the Centre for Health Science in Inverness. There were 965 medical students at the school during the 2017–18 academic year.

* Wales, West Midlands, North West and London are not listed as they were visited between 2012 and 2014.

We last visited Aberdeen School of Medicine in October 2012.
Read the findings from this visit (pdf).

University of Dundee School of Medicine

In 1881 University College Dundee was founded, and in 1897 was incorporated into St. Andrews. In 1967 the University Of Dundee School Of Medicine came into formal existence. There were 877 medical students at the school during the 2017–18 academic year.

We last visited Dundee School of Medicine in July 2009.
Read the findings from this visit (pdf).

University of Edinburgh Medical School

Edinburgh Medical School is one of two schools at the College of Medicine and Veterinary Medicine and was established in 1726. Edinburgh Medical School is spread across several campuses at Little France, Western General Hospital, the University Central Area and Royal Edinburgh Hospital. There were 1,307 medical students at the school during the 2017–18 academic year.

We last visited Edinburgh Medical School in July 2008.
Read the findings from this visit (pdf).

University of Glasgow School of Medicine

Glasgow School of Medicine was established in 1751. Since 2002 it has been located in the purpose built Wolfson Medical School Building. There were 1,326 medical students at the school during the 2017–18 academic year.

We last visited Glasgow School of Medicine in 2014.
Read the findings from this visit (pdf).

University of St. Andrews School of Medicine

The University of St. Andrews was founded in 1413. It is not currently approved to award a UK primary medical qualification (PMQ), so students of St. Andrews graduate with a BSc (Hons) Medicine after three years of study and then transfer into year three at a partner medical school to complete their PMQ, which is awarded by the partner school. There were 483 medical students at the school during the 2017–18 academic year.

We last visited St. Andrews School of Medicine in September 2014.
Read the findings from this visit (pdf).

ScotGEM

In addition to the medical programmes offered by the five medical schools, Scotland's first graduate entry medicine programme, ScotGEM, will launch in September 2018. ScotGEM is jointly provided by St. Andrews and Dundee Schools of Medicine, and is going through our new programme quality assurance process, which is separate to this review. We did not visit ScotGEM as part of this review as there are currently no students on the programme, however we did hear about the aims and opportunities of the programme on our visits to other organisations.

SDMEG

The Scottish medical schools and NES are members of the Scottish Deans Medical Education Group (SDMEG), which aims to promote joint working and collaboration among the members. We met with the SDMEG as part of the review.

UKAF - Scotland

Our senior management team formally engage with the medical schools via SDMEG, NES and other medical education providers as well as other partners and key interest groups through our UK Advisory Forum, which meets in our Scotland office. Our Scotland team also delivers a programme of interactive workshops for doctors in training and medical students in partnership with health boards, NES and medical schools**.**

What did we do?

To better understand the experience of medical students and doctors in training in Scotland, and to make sure their experience meets our standards, we visited eight health boards, as well as the five medical schools and the deanery. The health boards we visited were;

- NHS Ayrshire & Arran – University Hospital Crosshouse
- NHS Fife – Victoria Hospital
- NHS Grampian – Aberdeen Royal Infirmary
- NHS Greater Glasgow and Clyde – Inverclyde Royal Hospital
- NHS Lothian – Royal Infirmary of Edinburgh, Royal Hospital for Sick Children
- NHS Shetland – Gilbert Bain Hospital
- NHS Tayside – Ninewells Hospital
- NHS Western Isles – Western Isles Hospital

Visits took place between October and December 2017. The findings in this report, and the individual reports on each organisation visited, are based on these visits.

During the visits, we spoke with medical students, doctors in training, their educators and management teams at each organisation to get their perspective on how education and training is working. We asked each of these groups questions mapped to our standards.

You can find examples of the questions we ask different groups on our website.

Our visit teams consist of medical and lay associates with relevant medical and educational expertise, including medical students and doctors in training. Members of our staff are part of the teams, bringing with them their expertise in checking the quality of medical education and training across the UK.

Gathering evidence for our visits.

We receive regular updates from the Scotland Deanery on their progress in addressing concerns they have identified through their local quality management processes. We also get an annual report from the medical schools with updates on the medical programme and any concerns they have identified. Both of these sources of information helped us plan our visits.

Before visiting, we also asked each organisation to give us further information on how they meet our standards to inform our review and help us identify areas to focus on during our visits.

Evidence from our national training surveys

We have well-developed evidence about postgraduate training, and our annual survey of doctors in training, the national training survey, has a very high response rate. The response rate for the 2017 running of the survey, the most recent edition for the purposes of this review, was 96.6% in Scotland and 98.3% across the UK. This survey gives us a great deal of information on the quality of postgraduate training across the UK.

We also used responses to our national training survey of trainers, which had a response rate of 47% across Scotland, and 53.6% UK wide, as another source of evidence.

Evidence from a student survey

In addition, we ran a bespoke survey of students before the visit. We asked each medical school to send this to all medical students across Scotland and the response rate was 25%. This is in line with the response rate for previous reviews, and the results were used to help identify areas to focus on during our visits.

Considering specialties as part of our visits

Regional and national reviews give an opportunity to consider and sample several specialties and stages of postgraduate training in more detail. For this review, we focused on the following training programmes.

- Foundation programme
- Core medical training
- Core surgical training
- General (internal) medicine
- General surgery
- Geriatric medicine
- Paediatrics

It is important to note that our national review was not a programme review; rather we used these specialties to explore how organisations managed the quality and safety of medical education and training across Scotland. By selecting these specialties we were able to compare the same specialties in a range of settings and locations across Scotland, to gain a national overview.

Themes across Scotland

Safety of patients and doctors in training

Within Scotland, there are six health boards that have departments or units that are in our enhanced monitoring process.* We visited four of these health boards as part of this review.

Enhanced monitoring is a distinct GMC process from our national reviews, and national reviews are not the best way to address serious concerns about patient and trainee safety, which will require more timely and forensic intervention. This is why, when planning the national review, we purposefully avoided visiting departments in our enhanced monitoring process. For example, we visited Aberdeen Royal Infirmary, NHS Grampian, but did not visit general surgery on our visit to this local education provider, which was at the time of our visit in enhanced monitoring.

Shortly before visiting general surgery at Ninewells Hospital, NHS Tayside, the unit was placed into enhanced monitoring following a referral from the deanery. We were clear on the visit that the visit to Ninewells as part of the national review visit was separate to the enhanced monitoring process, which was picked up outside of the visit. A separate enhanced monitoring visit to general surgery, led by the deanery with our support, took place in March 2018.

What happens if we find a serious concern on a visit

We have a process for dealing with a serious concern that we identify on a visit. This process gives us clarification or additional information on what may pose a risk to patient or trainee safety, which will help us identify the best course of action to take, which could be enhanced monitoring.

On our visit to University Hospital Crosshouse, NHS Ayrshire & Arran we identified a potential serious concern relating to the transfer of patients within the acute medical pathway out of hours, and we raised this on the visit with the health board and the deanery.

Following the response from the deanery and Ayrshire & Arran we were assured that this issue was being addressed by the board, and was being monitored by the deanery, and remedial action was taken. We were satisfied with this response, and have included the monitoring of this as a requirement for NHS Ayrshire & Arran in their report. This is not subject to enhanced monitoring.

* You can find publishable enhanced monitoring cases on our website at www.gmc-uk.org/education/reports-and-reviews/enhanced-monitoring-reports.

Findings

The purpose of our regional and national reviews is to provide assurance against our standards of how medical education and training is quality managed locally.

You can see our findings for how each site visited is complying with the standards and requirements set in *Promoting excellence: standards for medical education and training* in the individual site reports. We have detailed areas that are working well, as well as areas where improvements are needed across Scotland under each of the five themes in *Promoting excellence*.

Theme 1: Learning environment and culture

For this review we wanted to make sure the environment and culture for education and training meets the needs of learners and educators, is safe and provides a good standard of care and experience for patients. Across the 14 visits that made up this review we set seven requirements where action was needed for our standards under this theme to be met, and ten recommendations. We also identified a number of areas working well and of good practice.

Raising concerns

During our visits to the deanery and the medical schools we heard of the different ways that learners and educators can raise any concerns they might have over patient safety and the standard of care or of education and training.

We heard from the deanery that although leaners should use local processes in the first instance – for example through the local education provider's incident reporting system, Datix, or to their educational or clinical supervisor, concerns could also be raised directly with the deanery through the 'notification of concern' option on the deanery website.

We heard similar examples from the medical schools we visited of ways that medical students can raise concerns. For example, medical students at Aberdeen School of Medicine can do so through the school website. And we heard of similar online systems at Edinburgh Medical School and Glasgow School of Medicine.

We also heard that medical students could raise concerns with named contacts at either the local education provider or the medical school. The medical students we met with on our visits at the medical schools and at local education providers were generally aware of how they could raise concerns and had positive experiences of doing so. Medical students we met with did not use Datix.

On our visits to local education providers we heard about some of the challenges to the use of Datix. For example, the time it can take to log an incident on Datix, and we heard that feedback was not always provided once an incident had been logged.

We also heard positive examples of Datix as an educational tool. Learners and educators we met with on our visit to Ninewells Hospital, NHS Tayside, provided examples of this and we have identified this as an area working well in the NHS Tayside report.

We also set a recommendation at Victoria Hospital, NHS Fife to review how they use Datix as an educational tool where we found it used less effectively, and we encourage the sharing of learning across all health boards.

Identifying learners at different stages of education and training

Making staff aware of the different levels of competence of learners, so that learners are not expected to work beyond their competence, can be a challenging area and is something we have identified as a potential concern through previous national and regional reviews.

This awareness is particularly important for those on the 'second on call rota', sometimes referred to as 'senior house officers, or SHOs'. We discourage the use of this terminology as it confuses a wide spectrum of level of experience. In such scenarios it is important that the person summoning help from the doctor on this rota knows the level of competence they can expect, which could range from those in the second year of the Foundation Programme (F2) to those in the second year of core/specialty training, and that the level is appropriate for the clinical situation. It is also important that the learner is not put in a situation where they feel expected to work beyond their competence.

The deanery has been addressing this through their *#saynotoSHO* campaign, and we also heard examples of other local initiatives on our visits. For example on our visit to Victoria Hospital, NHS Fife, we heard that the use of coloured name badges enabled staff, including non-clinicians, to identify levels of learners' competence. We acknowledged this as an area working well in the NHS Fife report due to how well embedded we found this approach was at the site and across different professions.

Although we heard of local initiatives, as described above, we did not hear of a consistent approach across the health boards that we visited. This variation could lead to confusion as staff moved from one health board to another. We have set a requirement for the deanery to take a lead on identifying and promoting a consistent national approach to this whilst recognising the work that has been done and that this is a UK wide challenge.

We also heard examples from each of the five medical schools of how they make sure their medical students are identifiable especially when on clinical placements, when there may be students from other medical schools on site.

Rota design

Organisations must design rotas that are safe for patients and for learners, and support learners to meet the requirements of their curriculum and training programme.

During this review, we heard of the challenges that organisations face due to gaps in their rotas. And while we identified no concerns over the impact of these gaps on patient safety, we have set two requirements for local education providers to address the impact of gaps in rotas on the ability of learners to meet their curriculum.

- At University Hospital Crosshouse, NHS Ayrshire & Arran, we heard of the impact rota gaps had on training at the site, and that service pressures could make it difficult for learners to access training, eg attending outpatient clinics.

- At Inverclyde Royal Hospital, NHS Greater Glasgow and Clyde, we heard similar experiences. We also heard of difficulties in getting consultant sign off on procedures or consultant teaching due to the consultants' workload.

We also found on our visits that a frequently used process to mitigate rota gaps was the appointment of non-training junior doctors, often post F2, who were offered short term posts that included promises of personal development and access to training and supervision. This has been found in other regions and countries we visited over the last two years.

Appointments of this nature keep young doctors in NHS services and give them the opportunity to embed or broaden their skills and competencies, however it is important that they do not reduce access to training experiences both within service (eg supervised outpatient clinics) and within taught programmes (eg simulation or bedside teaching) for those doctors training within structured training programmes.

Resources and facilities

In general, we found that the resources and facilities for students on all the medical school university campuses were excellent, and this was identified as an area working well in a number of reports. Access to clinical skills equipment and technology enhanced and simulation based learning was highlighted as areas working well on our visits to Aberdeen School of Medicine and St. Andrews School of Medicine, and on the latter visit the team were impressed by the GALEN interactive educational tool, a virtual learning environment which enables students to record and access their learning.

However, on our visits to health boards we found some challenges. At our visit to Ninewells hospital we identified an issue with the way some Dundee School of Medicine medical students were gaining IT access, and this was raised with the school, which took immediate action. On our visits to Royal Inverclyde Hospital NHS Greater Glasgow and Clyde we heard of challenges in providing the physical space for learners to store their personal belongings and to rest, and have set a recommendation to review this. We also saw some of the benefits of technology on our visits to NHS Shetland and Western Isles where technology enabled learners in remote and rural locations to access teaching being delivered on the mainland.

Whilst visiting NHS Grampian, we had the chance to view the NES mobile clinical skills unit. This unit was developed to support the delivery of clinical skills training to a variety of medical professions and community groups across Scotland.

Theme 2: Educational governance and leadership

During our visits we wanted to make sure that organisations have effective systems of educational governance and leadership to manage and control the quality of medical education and training. We have set three requirements where action was needed for our standards to be met under this theme, and have made five recommendations. We have also identified 17 areas working well.

Educational governance

During our review, we were keen to hear how the educational governance structures work within each organisation visited, but also how these organisations work together to support medical education and training. In general we found good working relationships between the medical schools, health boards and NES, particularly around educational governance and the sharing of information. This has been highlighted in a number of visit reports.

We have previously highlighted the interprofessional leadership at NES as an example of good practice, and it was clear to us how the deanery works with the other directorates in NES to mutual benefit. An example of this is the NES digital strategy which works across different systems and disciplines to support learners and educators and which we have also recognised as an example of good practice.

We also found examples of involving learners in educational governance. For example, at our visit to Inverclyde Royal Hospital, NHS Greater Glasgow and Clyde we saw the benefits of the chief resident role in helping the learner voice be heard in local governance groups, and have identified this as an area working well in the visit report. We have also identified the involvement of medical students in the governance of the programme at St. Andrews as an area working well in their report.

Joint working, collaboration and the sharing of learning

We were also keen to learn through this review how far quality management processes at the deanery had aligned since the creation of a single deanery in 2014. In the deanery report we have identified the Professional Support Unit as a good example of a ‘one deanery approach’. Previously support for doctors in training was managed regionally but the Professional Support Unit was launched in 2016 with the aim of proving a consistent, national approach to support.

We could also have used the deanery’s quality management processes as a further example of this, as these processes too have been aligned under a one deanery umbrella. One aspect of the deanery’s approach to quality management we heard about was the

quality review panels, which meets annually to consider quality data for each programme, including foundation and undergraduate training across Scotland, and to prioritise the quality work plan for each programme for the year. We also heard of moves to do joint visiting between the deanery and medical schools. And we identified the involvement of lay representatives in these quality management processes as an area working well.

We met with members of the Scottish Deans Medical Education Group (SDMEG) on our visit to the deanery. The SDMEG formed in the late 1990s to promote sharing and collaboration across the Scottish undergraduate medical programmes. Its membership includes representatives of the six Scottish medical programmes (five medical schools plus ScotGEM) and the deanery.

Examples of the collaborative work of SDMEG include contributing to the development of a Scotland-wide approach to the recognition and approval of trainers' framework, an undergraduate survey on clinical placements and a fitness to practice group where learning is shared across the schools. The group also makes sure medical programmes are represented externally, for example the board of academic medicine and the Scottish foundation programme board. The SDMEG has also worked with the deanery on developing a joint approach to quality management.

A further example of collaboration across Scotland is The Taskforce to Improve the Quality of Medical Education (TIQME), which includes representation from the deanery, medical schools and health boards, with GMC representation as observer status. We didn't meet with the group as part of this review, but we heard of its work from those we did meet with and the value placed on there being a regular forum for organisations involved in medical education and training to meet.

St. Andrews graduates

Graduates of St. Andrews School of Medicine transfer to year three of their partner medical schools to complete their primary medical qualification. Partner medical schools include the other four Scottish medical schools as well as Manchester and Barts and the London. As well as current medical students at St. Andrews as part of this review, we also met with St. Andrews graduates at our visits to the other schools in Scotland.

We heard from the senior team at St. Andrews that the school has an established process for sharing information on learners with each partner medical school, and that the SDMEG, helps align curricula across the schools. This view was supported by feedback at our visits to partner medical schools, and we heard positive views of how St. Andrews graduates fit into their partner school from the educators we met with. The St. Andrews graduates we met with were also positive about their support during their transfer by St. Andrews and the partner medical school.

On our visit to Aberdeen School of Medicine we learned that there had been some concerns over the transfer of graduates into year three of the Aberdeen programme. This was because the Aberdeen programme starts in May and St. Andrews graduate in

September and miss eight weeks of the programme. We heard that Aberdeen had put support in place to mitigate this for this academic year, but we have set a recommendation for Aberdeen to continue to monitor the effectiveness of this support.

Widening access to medicine

We heard during our visits various initiatives aimed at widening access to medicine, including the involvement of all five medical schools in Reach Scotland. Reach Scotland is a national project that gives information, advice and guidance on applying to high demand professional subjects including medicine. It is managed and delivered by five partner universities: University of Aberdeen, University of Dundee, University of Edinburgh, University of Glasgow and University of St. Andrews.

We have recognised the approach taken by Glasgow School of Medicine as an area working well. The school has a number of programmes in place to widen participation and is doing some excellent work in this area with over 20% of their students recruited as a result of the initiatives which include: a university-wide Reach programme that the school is part of, summer schools to help upskill potential students, lower entry requirements, and the Glasgow access programme.

There is also a pre-medical school course that is run and guarantees a place in the Medical School if the students pass the written assessments. The school is meeting the Scottish Government's requirements for widening participation but still want to increase their numbers and continue to explore further ways of doing this.

We found further examples of good work in this area at the other medical schools visited, and information on these areas can be found in the report for each school.

Differential attainment

We heard on the visit of the ongoing work by the deanery in the area of differential attainment. The deanery has been one of the pilot organisations for our differential attainment project and their action plan, which involves all organisations visited as part of this review, is recognised as being an exemplar by our project team.

The project will be rolled out across the UK in 2018 and we heard from the deanery they have aspirations to continue their work in this area. We heard further examples of this piece of work from the other organisations visited as part of the review, which is being driven through TIQME.

Theme 3: Supporting learners

Throughout our visits we were keen to see how learners were supported by the educational organisations we visited. Across the 14 visits as part of this review we identified a number of areas working well (ten), no requirements but four recommendations under this theme.

The medical students we met with in general felt that their access to educational and pastoral support was good, and we heard positive examples of such support from the medical schools.

We have however identified two areas we feel should be reviewed from our visit to Aberdeen School of Medicine and have set two recommendations under this theme. Firstly to review the school's Regent Scheme, which assigns each students a senior staff member who they can access for support, to make sure there is a consistent student experience. And secondly to review their processes for identifying low level concerns about student performance, behaviour or conduct when on clinical placements. The team felt that the use of a paper based system could make it more difficult to identify patterns that might prompt a supportive intervention.

We have mentioned the deanery's Performance Support Unit earlier in Theme 2 and we received positive feedback on this source of support throughout our visit. We heard that much of the support was delivered locally under national guidance.

On our visits to health boards we made two recommendations. We have asked Royal Inverclyde Hospital NHS Greater Glasgow and Clyde to review the physical facilities for learners. And from our visit to NHS Lothian we identified that there may be a need for additional support for learners from outside of Scotland who then come to train in Scotland to help them understand the differences in law and terminology.

Overall, the visit team were impressed with the support, both educational and pastoral to learners across the organisations we visited. We also identified no concerns over bullying or undermining on any of the visits.

Theme 4: Supporting educators

As part of this review we wanted to make sure that educators have the necessary skills and knowledge for their roles, and get the support and resources they need to deliver effective education and training. We have set one requirement and one recommendation under this theme, and have identified seven areas we consider to be working well.

Supporting educators

We met with a wide range of educators, in a variety of settings during our review.

On our visit to medical schools, we heard examples of the training and support that universities and local education providers give to those with an educational role. We also heard that educators were aware of and willing to raise any concerns they might have about their roles and performance with the medical schools or local education providers.

We also heard of the pressures that service delivery can have on education and training delivered in local education providers. We have set a recommendation at Glasgow School

of Medicine that time in job plans for clinical educators is monitored to make sure there is sufficient time for undergraduate education. We have also set a recommendation for Edinburgh Medical School to review arrangements for administrative support for clinical placements as educators we met with on our visit to the school reported a lack of resources from the school, which was not always picked up by the local education provider.

We learned of examples of support for educators on our visits to local education providers, and have highlighted where we feel this is working well in the reports for Royal Infirmary of Edinburgh, NHS Lothian and University Hospital Crosshouse, NHS Ayrshire & Arran.

We have set a requirement following our visit to Inverclyde Royal Hospital, NHS Greater Glasgow and Clyde to make sure time is included in job plans for educators to meet their educational responsibilities as we found this to be inconsistent across undergraduate and postgraduate teaching.

On our visit to the deanery we met with training programme directors for the programmes visited, and we heard that the training and support offered by the deanery was 'outstanding'. We received similar feedback from the Foundation Programme Board who we also met with at the deanery visit. Again, we heard of the challenges that workload can have on those with both a clinical and educational role, but we also heard of the support in place for educational and clinical supervisors.

CEP – SEFCE

On our visit to Edinburgh Medical School we heard about the Clinical Educator Programme (CEP) provided by the South East Faculty of Clinical Educators (SEFCE), a partnership between three territorial health boards NHS Lothian, NHS Fife and NHS Borders, Edinburgh Medical School and St Andrews School of Medicine, and NES.

The aim of CEP, which has run since 2010, is to provide continuous professional development to clinicians involved in teaching medical students, for example through workshops, online teaching and an annual symposium. The feedback we received from those educators who had been involved in CEP was very positive.

GLINT – NHS Grampian

On our visit to Aberdeen Royal Infirmary, NHS Grampian, we learned of the Grampian Learning Initiative (GLINT).

The aim of GLINT is to provide a modular developmental programme and support network to educators who wouldn't normally work alongside each other, through practice based small group learning. The educators we met with who had been involved in GLINT valued the opportunity to discuss and share with those from other departments, although it was sometimes challenging arranging time to meet. The visit team saw this as potential good practice as more educators become involved.

Educators in remote and rural settings

On our visits to Gilbert Bain Hospital, NHS Shetland and Western Isles Hospital, NHS Western Isles we heard of some of the opportunities and challenges of delivering medical education and training in a rural general hospital. We were told that the generalist model of the healthcare provided at both local education providers visited also shaped the medical education and training delivered. We heard from learners that this helped them feel part of the wider team and gave them more opportunities for a wider exposure to a wider range of patients than in other local education providers. We also heard that the exposure to a broader range of patients, coupled with the smaller numbers of both learners and educators, meant that much learning took place informally on a one to one basis rather than through lectures.

The educators we met with at both health boards had all received training for their role, although some of the training was accessed remotely as we heard it can be difficult to attend training delivered on the mainland. Those we met with also felt well supported by the deanery**,** partner medical schools, particularly Aberdeen School of Medicine as well as their health board.

We heard examples of support for directors of medical education from their peers at neighbouring health boards, as well as other examples of joint working, support and collaboration.

We heard examples of educators covering multiple educational roles alongside their clinical duties, and where this happens it is important that there is adequate support in place. We have set a requirement of NHS Shetland in regard to support for educators. We also heard of challenges in recruiting and retaining staff which can affect workload, both educational and clinical.

It was clear from our visits how intertwined service and training were, and that doctors in training were vital in sustaining service in the short term, and in developing the consultant workforce of the future. This issue is one that extends beyond the scope of this report; however the visit team acknowledge the value of training in such environments and the significant contribution that training plays in helping to sustain health services in remote and rural locations.

Theme 5: Developing and implementing curricula and assessments

Our statutory responsibility for regulating curricula and assessments are different according to the stage of training. As part of this review we wanted to make sure that medical school and postgraduate curricula and assessments are developed and implemented to meet GMC outcome or approval requirements. We have set one requirement and seven recommendations as part of this review, as well as identifying 16 areas we consider to be working well.

Undergraduate curricula and assessment

On our visits to medical schools, we learned how schools develop and monitor their curricula systems to make sure our outcomes for graduates were met.

While we heard examples of how medical students, patients and public were involved at each of the medical schools visited, we were impressed on our visit to Aberdeen School of Medicine to hear the way that medical students, the public and patients were involved in the review of the year four curriculum. We also heard positive feedback on the remote and rural option in year four of the programme, and the experience and opportunities it provided, which echoed the views we heard from learners we met on our visit to NHS Shetland and NHS Western Isles. On our visit to St. Andrews we felt that the school could review how they involve patients and the public in their programme and have set a recommendation to reflect this.

We also identified the way that Dundee School of Medicine integrates clinical and basic sciences as an area working well. And at Edinburgh Medical School and Glasgow School of Medicine we acknowledged the way the curriculum clearly demonstrates how the outcomes for graduates are met.

We have set a recommendation for Edinburgh Medical School to review their assessment systems to make sure they are consistent. For example, we heard of variation in approaches to standard setting across the years, and at Glasgow School of Medicine we have set a recommendation for the school to review the consistency of marking in assessments carried out in clinical placements.

We also identified some concern over the capacity for medical students on some of the visits, and have asked Dundee School of Medicine and St. Andrews School of Medicine to continue to monitor capacity at Ninewells Hospital, NHS Tayside, and Royal Victoria Hospital, NHS Fife, as a result of feedback from learners we met with on our visits. This will be especially important when ScotGEM, the first Scotland graduate entry programme commences in September 2018.

We also identified local education providers where the undergraduate curriculum was covered well, for example Inverclyde Royal Hospital, NHS Greater Glasgow and Clyde

where medical students valued the input of clinical teaching fellows in their teaching, and at the Royal Hospital for Sick Children, NHS Lothian.

Postgraduate curricula and assessment

We learned on our visit to the deanery of the various ways that the deanery monitors the quality of training programmes, and takes action where action is needed to meet our standards.

Remote and rural medicine

We also heard of the focus on remote and rural medicine, which runs through the continuum of medical education and training. This report looked at the approaches to widening access to medicine at each medical school, and we heard at our visit to the deanery their view that the key to attracting a sustainable remote and rural workforce was early exposure. The development of ScotGEM is a further step in this, as St. Andrews and Dundee Schools of Medicine work with the University of the Highlands and Islands to develop and deliver this programme.

The next steps

Following our visits to Scotland, we have set out requirements and recommendations for each organisation in our detailed visit reports.

Each organisation we visit gives us an action plan against these requirements and recommendations, outlining the steps they have and will take to address these. We publish these action plans on our website and you should read them alongside the reports.

Through scheduled reporting at agreed dates, the Scotland Deanery and the medical schools will update us on their progress towards meeting these requirements and recommendations. The deanery will monitor updates on the requirements and recommendations from the health boards and will report back to us.

Sharing good practice and supporting partner organisations

We'll also look at how to share the areas of good practice with other patterns involved in medical education and training. We'll do this partly through the national review day, which we'll host in April 2018. This will be attended by representatives from the deanery, the medical schools and all the health boards, not just those that were visited.

We look forward to continuing to support all our partners across Scotland. We'll meet regularly with them to give advice and assistance to make sure that any challenges in meeting the requirements and recommendations of the national review can be addressed.

We will also take our learning from this review and apply it to our regional review of the north east of England, which is scheduled for autumn 2018.

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