NHS Shetland

Meeting:	**Board**
Meeting date:	**23rd June 2022**
Agenda Reference:	**Board Paper 2022/23/24**
Title:	**Medical Director's Annual Report**
Responsible Executive/Non-Executive:	**Kirsty Brightwell**
Report Author:	**Kirsty Brightwell, Medical Director**

1 Purpose

This is presented to the Board/Committee for:

- Awareness

This report relates to:

- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Annual review of Medical Directorate work and adherence to statutory and strategic requirements. Appendices: Duty of Candour annual report and Director of Medical Education Annual Reports.

2.2 Background

Professional governance of medical staff undertaken on behalf of the Board. Progress in establishing wider medical leadership and towards a sustainable medical workforce. Clinical Governance and Risk has moved under the Medical Directorate.

The Organisational Duty of Candour procedure is a legal duty setting out how organisations should tell those affected that an unintended or unexpected incident appears

to have caused harm or death. This includes the requirement to apologise and involve them meaningfully in a review of the events.

The Director of Medical Education report seeks to inform the Board of the activity to meet the GMC training standards and work with colleagues across NHS Shetland and within NHS Education for Scotland to ensure that we provide high quality, person-centred training.

2.3 Assessment

Professional governance procedures and delivery are described along with change in the emphasis of Appraisal.

Medical leadership progress towards a more disseminated approach.

Review of workforce and recruitment efforts.

Reconfiguration of Clinical Governance framework and management and reinstatement of the Risk Management Group plus a new Risk Management Strategy.

DoC Annual Report describes the process and our performance against this with 3 incidents triggering the Act.

2.3.1 Quality/ Patient Care

Appointment of Chief Nurse (Corporate) providing clinical leadership to Clinical Governance and Risk.

2.3.2 Workforce

Progress towards substantive workforce with innovative contractural models.

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

N/A

2.3.5 Equality and Diversity, including health inequalities

N/A

2.3.6 Other impacts

2.3.7 Communication, involvement, engagement and consultation

N/A

2.3.8 Route to the Meeting

- AMD Acute and Primary Care
- Primary Care Manager

2.4 Recommendation

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix 1: NHS Shetland Annual Duty of Candour Report 2021/2022
- Appendix 2: NHS Shetland Director of Medical Education Annual Report 2021/2022

NHS Shetland: Medical Director's Annual Report 2021-2022

Contents	Page
Preface	1
Professional Governance	2
Medical Leadership	3
Workforce Primary Care	4
Workforce Secondary Care and Mental Health	5
Clinical Governance and Risk	6

Preface

In 2019, the GMC commissioned and published independent research entitled "Fair to Refer" fair-to-refer-report_pdf-79011677.pdf (gmc-uk.org). This followed criticism of the disproportionate referrals for doctors from minority groups. The recommendations of this review are:

1. Improving induction, feedback and support for doctors new to the UK or the NHS whose role is likely to isolate them (such as SAS doctors and locums).
2. Addressing the systemic issues that prevent a focus on learning, rather than blame, when something goes wrong.
3. Ensuring engaged, positive and inclusive leadership is more consistent across the NHS.
4. Developing a UK-wide mechanism to ensure delivery of the recommendations.

Apart from the last point, these have become guiding principles. There is still more to do but the foundations are shaping up.

Professional Governance

Main issues this year

1. Succession Planning: the Appraisal Lead is shared with NHS Grampian. The Lead is due to retire shortly.
2. COVID has created challenges for all of us and there has been a move by the Chief Medical Officer to promote a "wellness" appraisal. Whilst maintaining the standards that the GMC expects, the Appraisal is an opportunity for doctors to share their thoughts, feelings and reflections, to be listened to and to consider further options of support either from within or outwith the organisation.

Background

The Medical Director is the Responsible Officer for NHS Shetland (the Designated Body). Doctors who work in multiple Boards should have the Board where they do the majority of their work as their Designated Body. They have a statutory duty to make recommendations for the revalidation of doctors to the GMC as set out in the Medical Profession (Responsible Officer) Regulations 2010 (as amended). This means that the RO must evaluate doctors' fitness to practise. This is achieved by having an Annual Appraisal system. Each doctor will have an Annual Appraisal with a qualified Appraiser. Every 5 years they must achieve the requirements of the GMC. The RO meets with the Appraisal lead to ensure that this has happened.

Progress this year

We have been successful in attracting a number of new Appraisers to work for NHS Shetland but the team is still small and therefore there is a concern re sustainability. We have joined up with the team in Orkney to provide resilience as well as the option to have an Appraiser/Appraisee outwith their employing Board.

The Appraisers have come together regularly to support each other and consider what other support and training they need. We are therefore in a good place to consider how we adapt to the changes that will inevitably come with the change in Appraisal Lead.

Data for 2021/22

Measure	
Number of Appraisers associated with NHS Shetland	7
Number of doctors with NHS Shetland as Designated Body	69
Number of Appraisals completed	69
Number completed after April for previous year	1
Number of recommendations to GMC for Revalidation	9
Number of deferrals	0
Number on-hold	<5

Medical Leadership

Background

Medical Leadership is vital in delivering high-quality care. This is vital as NHS Shetland works towards its goals of sustainability and new models of care to deliver the new Clinical Strategy.

Progress

The Board has 2 substantive Associate Medical Directors (Acute and Primary Care) providing 1 day a week each. The AMD for Acute is part of the Hospital Management Team and instrumental in recruitment work. The Primary Care Associate Medical Director was filled on an interim basis and recently this has been formalised through a recruitment process. Both AMDs are now integrated into the Clinical Governance changes set out below with the aspiration of improving patient outcomes and assurance to the Board.

Each consultant must have a job plan agreed with their employer on an annual basis as set out in their contract. This has been completed for 2021-2022. The AMD for Primary Care is working closely with the Primary Care Manager as part of the Health and Social Care Partnership to support work around sustainability of Practices and the Out of Hours's service. There is now a plan to complete the job plans for the employed GPs.

Both the GP Sub-Committee and the Consultants' Group continue to meet regularly. They feed into the Area Medical Committee, a statutory committee of the Board which reports to the Area Clinical Forum. It is a advisory/consultative committee to represent the views of the local medical profession. Although the meetings stalled during COVID, the committee has reconnected with a new Chair.

There has been a change in the Secondary Care Consultant representation at the IJB with the previous consultant being on maternity leave. However both Primary and Secondary Care have maintained representation at this meeting.

As services start to look at improvement work there are more opportunities for medical leadership. Having job plans in place will give a realistic picture of the capacity for these roles which are vital not only for improving patient outcomes but also shaping the future of our delivery and sustainability.

Workforce: Primary Care

Practice	Population	WTE GP Baseline	WTE GPs Employed
Yell	989	1.41	0
Whalsay	1044	1.41	1.40
Brae	2571	1.60	1.2
Walls	700	0.8	0.8
Bixter	1100	1.04	1
Scalloway	3693	2.40	2.60
Lerwick	8639	6.67	6.25
Unst	603	1.41	1.40

Hillswick and Levenwick are independent contractors. Hillswick has 1 full-time GP and an associate GP (to cover leave and training), Levenwick has a baseline of 3 WTE GPs but has locum cover to support the 3 part-time GPs who are permanent.

After a brief period filled by locum staff, this year has brought with it the appointment of a team of rotational GPs for Unst. This model has been accepted by the local population which were involved in discussions before recruitment. Unfortunately, the same model has not proved popular at advert for Yell and the team are looking at other options including an Advance Nurse Practitioner and reviewing our mutual support with the Scottish Ambulance Service. Yell continues to be staffed by locum GPs.

Early 2022 saw the start date of an ANP trainee and a new full-time GP in Brae creating a more resilient service. Following the resignation of the GP in Bixter last year, we have been successful in appointing a GP to work rotationally which will provide some continuity to the population there though there is further work to do to attract more staff.

Scalloway have seen a new GP start and a trainee ANP.

Rediscover the Joy continues to support many of our practices including the independent GP practices. The 3rd cycle of recruitment has completed with NHS Shetland continuing to benefit and contribute a supportive role to other territorial boards in setting up their own teams.

Workforce: Secondary Care

Junior Doctors

This year has continued to be challenging with changes to recruitment by NHS Education for Scotland. There have been a few unpredictable gaps emerging that have taken a lot of time and effort to plug by the AMD and HR team.

Consultant General Medical Physicians

4.0 Whole Time Equivalent (WTE); 2 full-time with no on-call commitment and 2 rotational postholders

No change – continues to require Bank cover especially for on-call

Consultant Anesthetists

4.0 WTE; 1 part-time post holder

No change – continues to require Bank cover

Consultant General Surgeons

4.0 WTE; 3 full-time post holders

the propleptically appointed Consultant General Surgeon has started to undertake regular on-call weekends reduced reliance on locum cover for the surgical team.

Consultant Paediatrician (Community)

0.6 WTE; fully recruited, no change

Consultants Obstetrics and Gynaecology

2.2 WTE; fully recruited (rotational posts)

Consultant Microbiologist

0.5 WTE (as part of service from NHS Grampian)

Consultant Public Health

1 WTE; became DPH

Workforce: Occupational Health

Doctor in Occupational Health – 0.4 WTE in post

Workforce: Mental Health

Consultant Psychiatrists

2.0 WTE; the only substantive consultant tendered her resignation in January 2022 with a long term locum also leaving.

Doctor in Substance Misuse

0.6WTE in post

Clinical Governance

This year saw the Executive Team lead a change in the framework of Clinical Governance to change the Clinical and Care Governance Committee to a Clinical Governance Committee which alongside the Joint Governance Group will provide a more direct route for assurance to the Board.

The first Chief Nurse (Corporate) was appointed in 2021 which brought the Clinical Governance team into the Medical Directorate. The Chief Nurse (Corporate) also provides the lead for Care Assurance, Excellence in Care and Patient Engagement.

The Clinical Governance team play a vital role in the organisation to help assure the Board that we provide high quality, safe and effective services but also to support clinicians to understand their role in this.

The team continue to support individuals to report adverse events and encourage reviews to be based on learning. There have been regular meetings with local Scottish Ambulance Service, Primary Care and Secondary Care representatives to look at joint adverse events and encourage improvements to be taken forward together. This has led to a specific project around the sustainability of emergency care on the outer isles.

There has been a review of the clinical audits undertaken for the Board to identify gaps and work towards a more systematic approach to this work.

The Sudden Death Group continues and 2021 saw the introduction of the National Child Death Review service. Clinical Governance will support the identification, commissioning and coordination of reviews as well as the completion of the relevant dataset to return to HIS. The learning from this will be reported from the Sudden Death Group to the JGG.

The team including risk management include individuals with specialist skills and there is acknowledgement of the need to look at succession planning and sustainability of these services.

Risk Management

Background

The Board retains responsibility for the management of risk in its entirety. The Board delegates the development and detailed work associated with its implementation to the Risk Management Group (RMG) which reports to the Board; the Medical Director is the Chair of this Group. It has overall responsibility for the integration, co-ordination and standardisation of risk management throughout the Board. It provides assurance to the Board on the establishment and implementation of risk management processes and systems.

Progress

This year saw the RMG re-established with regular, quarterly meetings. There was a review of all of the Corporate Risks as well as the Risk Strategy. The Audit Committee had a development session to improve their knowledge in terms of scrutiny of the risk process.

There have been new risks added including that of Cybersecurity with many Board members undertaking specific training to improve

There is a new risk template for managers to complete and the Clinical Governance team will support teams to embed the use of risk to inform their improvement work.

NHS Shetland Annual Duty of Candour Report 2021/2022

All health and social care services in Scotland have a Duty of Candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the Duty of Candour is implemented in our services. This short report describes how NHS Shetland has operated the Duty of Candour during the time between 1 April 2021 and 31 March 2022.

1. About NHS Shetland

NHS Shetland is responsible for health care for a population of around 23,000. Local Hospital Services are provided from the Gilbert Bain Hospital. In addition, visiting consultants from NHS Grampian provide out-patient clinics as well as in-patient and day-case surgery to complement the service provided by our locally-based Consultants in General Medicine, General Surgery, Anaesthetics, Paediatrics and Psychiatry. Community Health, Health Improvement and Social Care services are delivered from a network of locations, including health centres, resource centres, care centres, community centres and in people's own homes.

Shetland's Health and Care Vision:
Our Vision is that by 2025 everyone is supported in their community to live longer, healthier lives and we will have reduced health inequalities.

2. How many incidents happened to which the Duty of Candour applies?

Between 1 April 2021 and 31 March 2022, there have been 3 incidents where the Duty of Candour applied. A total of 58 adverse events/complaints have been considered for the Duty of Candour process with 55 of them not requiring the Duty of Candour process to be followed and three were considered to be Duty of Candour. These events include a wider range of outcomes than those defined in the Duty of

Candour legislation as we also include adverse events that did not result in significant harm but had the potential to cause significant harm.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	**Number of times this happened (between 1 April 2021 and 31 March 2022)**
A person died	1
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0
A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	2
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
TOTAL	**3**

To what extent did NHS Shetland carry out the Duty of Candour procedure?

For the first Duty of Candour event the patient was informed within 4 days that a formal investigation would be undertaken. The relevant person was offered an apology and this was accepted. The adverse event report was submitted 17 working days from when the patient first contacted the Health Board. The Duty of Candour process began 8 working days after the report was submitted on the electronic system. Investigations were completed within 2 days of applying the Duty of Candour, a total of 45 working days since reported. The relevant person was informed of the findings and areas for improvement and accepted a copy of the final report. They were also informed they could contact the health board if they had any further concerns or comments. The relevant person was pleased the organisation was looking at improving the education of medical staff. NHS Shetland met the timescales stipulated within the regulations for engagement with the patient and relevant persons.

The second Duty of Candour event was discussed with specialists in a tertiary referral centre and taking their advice, the relevant persons initially were not informed the Duty of Candour process was being undertaken due to patient circumstances. Subsequently a formal complaint was received and therefore the Duty of Candour process and complaints process were aligned. Investigations were carried out however the patient did not wish to be involved at this moment in time.

The third Duty of Candour was applied 44 working days from the incident date. Ideally this should be within 10 working days and this was exceeded. However, discussions had been held with the relevant persons and thus this allowed the formal investigation, which had already been commissioned, to include the relevant persons requirements. This was well within the 10 workings days to commission a review. The relevant persons were offered support, and communication continued throughout the adverse event process, even prior to the Duty of Candour process being applied. This communication allowed the relevant persons to add questions, concerns and requirements into the subsequent investigations. The Formal meeting with the relevant person occurred 19 working days from application of Duty of Candour. This was within the regulation requirement of meeting within 2 months. The Investigation report was provided to the relevant persons at the formal meeting, which was within the 10 days required. The final report was subsequently updated to include additional comments from the relevant persons. Follow up communication and support was offered. No response has been received to date. An improvement plan based on the final report has been implemented and all actions completed. The plan has been shared at Joint Governance Group, risk management meetings and team meetings to share the learning.

3. Information about our policies and procedures

What processes are in place to identify and report unexpected or unintended incidents that may require activation of the Duty of Candour procedure?

Every adverse event is reported through our local reporting system as set out in our Learning from Adverse Events through Reporting and Review Policy and Procedure. These are based on the Health Improvement Scotland (HIS) national adverse event

management framework. We continued to report monthly to HIS in line with the timescales set out for the national notification system.

The Medical Director and Chief Nurse (Corporate) undertake a weekly review of the incidents to identify any with a potential for the application of the Duty of Candour process. Consideration for applying the process is then assessed using the Duty of Candour checklist to aid decision making.

We identify through the significant adverse event review process if there were factors that may have caused or contributed to the event, which helps to identify Organisational Duty of Candour incidents.

What criteria do you use to assess whether the Duty of Candour procedure should be activated?

Through our adverse event management process and complaints we can identify incidents that trigger the Duty of Candour procedure. We use the Scottish Government organisational Duty of Candour guidance for implementation of the procedure. The Duty of Candour process map which includes a link to the guidance, the Duty of Candour outcomes (definitions), the apology factsheet and our Duty of Candour trigger checklist are all available on the Duty of Candour intranet page. There is also a section of useful tools and resources for staff.

Each adverse event is reviewed to understand what happened and how we might improve the care we provide in the future. The level of review depends on the severity (using the NHS Scotland risk assessment matrix) of the event as well as the potential for learning.

Recommendations are made as part of the adverse event review, and local management teams develop improvement plans to meet these recommendations. The learning summary template we use from HIS has been added onto the Datix Reporting System to enable the learning to be shared more easily both within the Board and externally.

The monthly learning bulletin has continued to be produced and shared bringing information into one location via a web page including learning from national sources: SPSO, adverse events network which includes from other Boards; national guidance e.g. SIGN, NICE and local learning from adverse events and other sources such as complaints, quality improvement.

To increase organisational learning from adverse events, in 2022/2023 we will use the Corporate Bulletin to highlight key messages /learning which have arisen as a result of reported adverse events.

What support is available to staff who are involved in unintended or unexpected incidents resulting or could result in harm or death?

All staff receive training on adverse event management and implementation of the Duty of Candour Act as part of their induction. This was extended to locums with an e-learning module on clinical governance and risk management which is also being completed by the wider staff groups. Awareness sessions and 1-1 sessions have been delivered to staff and teams. The Duty of Candour e-learning module for staff to complete is a module in our e-learning system. We do not routinely monitor the figures as it is a national module. Any member of staff who is involved in the Duty of Candour process is fully supported and the Clinical Governance and Risk Team highlight the requirements to them. We have noticed an increase in awareness from senior managers regarding the Duty of Candour process.

We know that adverse events can be distressing for staff as well as people who receive care. We have support available for all staff through our line management structure as well as through occupational health and resources are available on our intranet. We have also got in place a Trauma Risk Management (TRiM) team who provide a TRiM risk assessment for any staff who have been involved in a potentially traumatic incident at work.

We are also in the process of exploring Schwartz Rounds which are a supportive environment in which staff from all professional backgrounds can explore social and emotional aspects of care. They give staff the opportunity to reflect on their experiences, including both its rewards and frustrations. It is an intervention that

aims to support staff in their work that can improve both patient and staff experiences.

What support is available to relevant persons who are affected by unintended or unexpected incidents resulting or could result in harm or death?

Staff are open and transparent with patients and family when things go wrong. A lead clinician is identified to provide support to the family and would refer to the relevant services accordingly. The Medical Director is the Executive Lead and provides a written confirmation to the relevant persons.

What changes, learning and/or improvements to services and patient outcomes can you identify as a result of activating the Duty of Candour procedure and the required reviews that have taken place?

There have been a number of changes, learning and/or improvements made to services and patient outcomes as a result of activating the Duty of Candour including:-

- Training on DNA CPR forms
- Changing the discharge Proforma to reflect important discussions with patient such as DNACPR and ceiling of treatment care plans
- Ensuring discharge checklists are filled in pre-discharge
- The actions identified from the investigation findings have been included as part of the wider work to embed Daily Dynamic Discharge Approach (DDDA) in all ward settings. There has been a project around DDDA and included training in discharge planning for all Registered Nurses. The inpatient documentation has been amended to allow for additional information to be recorded around DNACPRs
- Room to be converted to a bereavement suite and a bid submitted for inclusion in the capital bid programme 2022/23 has been successful. The team are waiting for a date to start the building works
- Retraining of staff on the electronic system and identification of member of staff to be a champion of the system to provide consistency of documentation and training to all relevant staff
- Alert added to system to notify of admissions with particular issue highlighted

- Relaunched key guideline, escalation policy and safer staffing guidelines

What improvements/ changes, if any, have been made to the approach to considering and implementing the Duty of Candour process itself, as a result of activating the procedure?

We have continued to review and update how we include the consideration of Duty of Candour criteria on the Datix Reporting System.

4. Covid-19 Pandemic

Setting the context

What processes were put in place to manage the impact of Covid-19 when activating the Duty of Candour procedure?

The processes we have described above continued to remain in place during the pandemic.

Did the timeframe in which it took to review cases increase due to the ongoing pressures of dealing with Covid-19? If so, by how much?

The timeframe was not impacted by Covid-19.

How many or what percentage of the times when the Duty of Candour procedure was activated this year have been directly attributable to Covid-19?

There were no Duty of Candour events when the procedure was activated this year which have been directly attributable to Covid-19.

Practical Actions Taken

How has involving the relevant person been impacted by Covid-19? For example, involving relevant persons in review meetings and continuing communication.

The involvement of the relevant persons has not been impacted by Covid-19.

In light of the Covid-19 pandemic, what adjustments have you made to continue to involve relevant persons as required by the Duty of Candour procedure?

There have not been any adjustments made as we have continued with the processes outlined above.

The Duty of Candour procedure provisions reflect the Scottish Government's commitment to place people at the heart of health and social care services in Scotland. In light of this and the Covid-19 pandemic, how did you ensure a person centred approach was maintained when the decision was made to activate the Duty of Candour procedure?

We continued with the processes outlined above. In terms of progressing Duty of Candour during the Covid-19 pandemic, we have offered people a choice of communication methods eg by letter, email, video or face to face adhering to the Infection, Prevention and Control guidance in place at the time.

Learning for the future

Responding to the Covid-19 pandemic will have meant changes to NHS Shetland's policies and processes, including activating the Duty of Candour procedure for unintended or unexpected incidents resulting or could result in harm or death.

Duty of Candour Procedure

- **What changes, if any, to the way you consider and implement the Duty of Candour procedure will you continue with as the Covid-19 pandemic continues?**

We will continue to offer people a choice of meeting format as detailed above.

- **What difficulties have you encountered when reviewing unintended or unexpected incidents due to Covid-19? What learning can be taken away from these particular difficulties?**

We have not had any incidents due to Covid-19.

Provision of Healthcare Services

- **Has there been specific learning from activating the Duty of Candour procedure to unintended or unexpected incidents which have resulted in or**

could have resulted in harm and death which are directly linked to the Covid-19 response? If so, what has this learning been?

There were no Duty of Candour events so this is not applicable.

What other learning have you been able to identify as a result of applying the Duty of Candour procedure?

There is no other learning we have identified.

5. Additional information

Please provide any further information you think might be important or relevant. For example, ways in which discussion, decision-making and reviews linked with the Duty of Candour procedure have supported continuous improvements in delivering safe, effective and person-centred care?

We also continue to have a very thorough, team-centred approach to clinical pathway changes which also helps reduce risk in change.

This is the fourth year of the Duty of Candour being in operation and we continue to learn and refine our existing adverse event management processes to support implementation of the Duty of Candour outcomes.

As required, we have submitted this report to Scottish Ministers and we have also published it on our website.

If you would like more information, please contact our Corporate Services Team in NHS Shetland.

Scotland Deanery

Director of Medical Education Report

NHS Board	Shetland			
Responsible Board Officer	Dr Kirsty Brightwell			
Director of Medical Education	Dr Pauline Wilson			
Reporting Period	**From**	4 August 2021	**To**	2 August 2022

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Jill Murray at jill.murray@nhs.scot or 01382 932788.

Please complete and return to jill.murray@nhs.scot by **5pm Wednesday 15 June 2022.**

1. Educational Governance

1.1 Does the full Health Board itself receive a regular report to support its governance responsibilities around the quality of postgraduate and undergraduate medical education and training?

- **How often does it receive a report around educational governance?**
- **What is covered in these reports?**
- **Is there a board member with responsibility for MET?**

- **How often does it receive a report around educational governance?**
  The DME report is included as part of the Medical Directors annual report to the Health Board

- **What is covered in these reports?**
  The minutes and action tracker from the Medical Education Governance group go to the Joint Governance Group which then reports to Clinical care and Professional Governance Committee (CCPGC). The CCPGC reports to the Integrated Joint Board and NHS Shetland Board. The DME report is included in the annual report to NHS Shetland's Board.

- **Is there a board member with responsibility for MET?**
  The chair of the Clinical and Professional Governance Committee has responsibility for providing the Board with assurances regarding governance as a whole and this includes Medical Education and Training.

1.2 Is there a Health Board committee with responsibility for the governance around the quality of postgraduate and undergraduate medical education and training?

- **What is it called?**
- **How often does it meet?**
- **What data and information is considered by this committee?**

- **What is it called?** Medical Educational Governance Group (MEGG)

- **How often does it meet?** Monthly

- **What data and information is considered by this committee?** MEGG considers operational, educational and strategic issues
  Operational issues:
  - Vacant posts and rota gaps
  - Planning for gaps in staffing
  - Rota's
  - Induction

- Monitoring of hours
- ACT funding
- Equality, diversity, and inclusivity is a standing item on the agenda
- Feedback from junior doctors forum via junior doctor representative

Educational issues:

- Ensuring rota matches the curriculum requirements for each grade of trainee
- Discussion on ACT funding to match with medical student teaching and training
- Monthly teaching programme
- Educational opportunities that would benefit the wider Multi-disciplinary Team

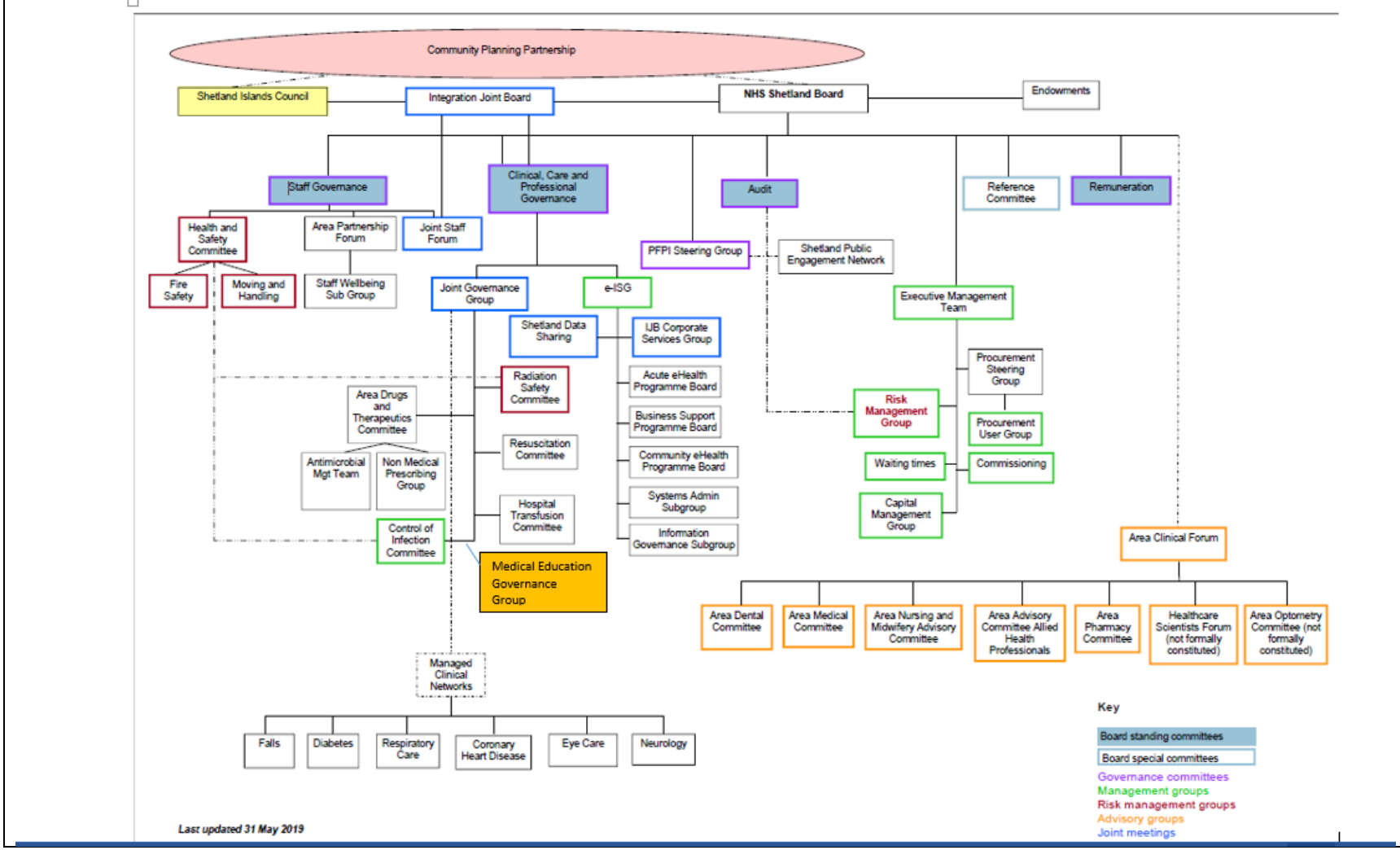
Strategic:

- Medical staffing and where trainees fit into the model of health care provision in Shetland
- Work with University of Aberdeen about accommodating increasing numbers of medical students
- The Medical Education Governance Group is a forum where professional groups involved in education and training come together to discuss their own professional education and training agendas; this allows those involved in training an oversight of the opportunities afforded in NHS Shetland and provides a forum for joint learning as well as strategic decision making – for example accommodation needs.

The fact that this group ties together the operational and educational nature of hosting medial students and junior doctors it allows for a system wide approach with tangible solutions to problems that could either affect service provision or training.

The membership of the group includes other members of the MDT team involved in teaching and training. There are also representation from the Executive management Team and Human Resources Department. There is trainee representation to the MEGG.

1.3 Is there a governance committee structure that links the delivery of education and training in LEPs to either the Health Board or the Health Board's educational governance committee? If there is, can you describe the elements of that and how information flows to the Board/Board committee? (You may wish to share an organogram if there is one that described the committee structure.)



1.4 Describe the quality control activities in relation to MET that have been undertaken by your HB in this training year?

- Medical Education Governance Group (MEGG) meets once a month – it has continued to meet during the pandemic via TEAMs
- Trainee representative's sit on the Medical Education Governance Group
- Trainees have regular contact with the Medical Director of Education
- RAG data is discussed at MEGG and at a consultant group. The Medical Director and Chief Executive attend the consultant's group so are sighted on any areas of good or challenged practice.
- Feedback from training is collected and informs changes to training content

In April 2022, the University of Aberdeen medical school team undertook a formal visit to review medical student teaching and training as well as facilities. The team were:

- **Prof Colin Lumsden**, MBChB Programme Lead
- **Dr Wendy Watson**, MBChB Year 5 Lead
- **Dr John McKeown**, Head of GP Teaching
- **Ms Morag Simpson**, MBChB Years 4 & 5 Administrator
- **Ms Ulrike Sperling**, ACT Officer

During the visit the team met with local University Block Leads, Clinical Development Fellows, members of the MDT teaching team and medical students. They also reviewed the teaching facilities and were given a demonstration of how we use the ACT funded teaching kit. There was a Medical Education Governance meeting where the team met members of the Executive Management Team. The team also inspected the medical student accommodation provided by the Board.

1.4 Are there forums within your HB whereby senior officers (CEO, MD) or site-based senior clinical management have regular, scheduled meetings with trainee doctors to discuss their training and receive feedback? Please provide full details.

- The Medical Director if possible, meets with the junior doctors at induction
- Director of Medical Education meets with all new trainees at induction and informally throughout the block
- Acute Services Director and Medical Director are members of the Medical Education Governance Group as is the Associate Medical Director for Primary Care so they are aware of feedback from the trainee representatives concerning operation and educational issues affecting trainee doctors.
- There is a junior doctor's forum and the junior doctor representative is a member of MEGG.

1.5 How are learners made aware of who is responsible for what within education for your organisation.

- An induction handbook is sent out to all trainees prior to starting in Shetland with deals of personnel
- Director of Medical Education meets with all trainees at induction and the educational organisational structure is discussed with them
- NHS Shetland links into the North Deanery induction where they meet the Director of Medical Education for NHS Grampian and the Postgraduate Dean.
- International Medical Graduates are linked into the Grampian mentoring support structures
- Each trainee has a named joint Educational and Clinical Supervisor – due to the small nature of the orgainsation the trainees work on a day to day basis with their supervisors.

1.6 If your review of quality management data highlights a number of new red flags in a particular department how do you address that?

- NHS Shetland is a small rural hospital site. This allows for early identification of issues and feedback to the departments
- All RAG data and other trainee feedback data is discussed at the MEGG so we can adopt a Multi-disciplinary approach to solving any issues raised
- Areas of concern or good practice is also discussed at the consultant's group
- The DME feedbacks directly to the department about any concerns raised or red flags and works with the department to address the underlying issues that has resulted in issues developing. After working with the department to address the concerns the DME keeps in contact with the department and trainees to ensure that the issues have been resolved or there is evidence of improvement.

1.7 What are the mechanisms in place for trainees to receive feedback from DATIX?

The Associate Medical Director (Acute) worked with the Clinical Governance department to ensure that there are robust mechanisms in place to ensure learning form datix/incidents. In 2021, a Chief Nurse (Corporate) was appointment and their portfolio includes clinical governance - work is ongoing to ensure that patterns are identified better through the datix and governance reporting systems.

Mechanisms include:

- Datix and incidents are discussed at ward governance meetings and recorded on ward action trackers
- Learning summaries are sent out to the consultants and trainees by the Associate Medical Director (Acute)
- Monthly clinical governance meetings where incidents/audits and cases are discussed by the wider teams.

1.8 At each site, how many trainee doctors have been involved in an SAE?

Site	Unit/Specialty	Number of SAE	Was the Deanery notified and involved in the follow up?
Gilbert Bain Hospital	**Medical and surgical**	**Nil**	**N/A**
Lerwick health Centre	**GP training**	**Nil**	**N/A**

1.9 At each site, how many trainee doctors have required 'reasonable adjustments' to their training in relation to a declared disability?

One trainee – this resulted in less than full time working pattern with rota specific adaptations – no out of hours work or overnight shifts.

1.10 How do you ensure educators are appropriately trained and that their training is kept up to date?

- New supervisors attend FDA approved training
- Educators are encouraged to attend regional and national education conferences such as NES Medical Education Conference
- Educators are invited to the Medical Education Governance Group
- Educators are encouraged to attend forums arranged by Training Programme Directors (TPD) e.g. IMT supervisor links into NHS Grampian TPD Internal Medical Trainee update sessions
- GP TPD links in with GPStR Educational Supervisors and is arranging up-date sessions for the hospital based clinical supervisors
- Educator Training is reviewed as part of the appraisal process – Role of trainer

The new Training Programme Director for Rural Tract GP training has met with the local clinical supervisors and medical education administrator.

1.11 Describe the mechanisms in place to ensure all educators have appropriate time in their job plans to meet their educational requirements?

- The Director of Medical Education has 2 session allocated for the role
- Educators have allocation of 1 hour per week per trainee
- Each consultant is encouraged to keep an up to date job plan
- Education component of job plan is reviewed at appraisal

1.12 What educational resources and funding can educators' access?

- Each consultant has a study leave budget
- Educational supervisors are encouraged to attend NHS Grampian Medical Education symposium
- Educational and clinical supervisors are encouraged to attend NES Medical Education programme
- Study leave support is available for potential educators to attend FDA approved Education Supervisor training

It is worth noting that the provision of high-quality digital access to training/educational resources has improved since 2020 and this has been of benefit to remote and rural sites. This has resulted in easy of attending educational meetings and has cut the need to travel (which come out of the study leave budget). The only issue with attending digital teaching and training events is safeguarding time and not being pulled back into work related activities. The continuation of high-quality online training will benefit remote and rural boards.

1.13 Is support available to educators when they are dealing with concerns? Please provide full details.

There are robust mechanisms in place for educators dealing with concerns:

- The Medical Education Governance Group (MEGG) is the ideal forum to raise general concerns with regards to the teaching and training environment.
- As the MEGG sits embedded in NHS Shetland's governance structure there are internal mechanism for escalation of concerns
- The DME sits on various external groups and is part of the DME network – this provides mechanisms to be sighted on developments or challenges that could face Local Education Provider and local educators
- Educational supervisors are part of a larger specialty network e.g. ES for internal medicine meets regularly with the TPD and other ES for IMT in Grampian – this is helpful for raising concerns for a particular curricular programme
- Regular contact with the TPD for Rural Tract GP programme – this gives an opportunity to discuss challenges and educator concerns
- The DME is a member of the Tutelage Group, University of Aberdeen – at each meeting a verbal or written report is provided on the educational environment in NHS Shetland

NHS Shetland has also submitted a bid through ACT for a GP session to support medical student placements in Shetland – the role will include support to GP undergraduate educators.

1.14 How do you ensure there are sufficient opportunities for learners to undertake educational CPD?

- Medical Education Administrator publishes a weekly teaching timetable that outlines programme specific teaching as well as local teaching opportunities
- Trainees are encouraged to attend bleep free programme specific teaching
- There are opportunities to attend local teaching sessions e.g. surgical skills, scenario-based simulation teaching as well as lecture-based teaching
- In 2021, the rural general hospitals have set up a monthly “Grand Round”. This provides an opportunity to network and discuss cases. Trainees are encouraged to attend and present.
- Monthly RCP Edinburgh evening medical update teaching
- ILS and local ALS courses
- Trainees attend programme specific Boot Camps
- Prior to blocks in Shetland foundation doctors are given the opportunity to attend Rural Boot Camp
- Monthly journal club
- In 2021, we have established regular teaching and training updates from the GMCs education department
- Trainees attend locally run Intermediate Paediatric Life support training – half day session per block

In 2020 - 22, there have been challenges to the delivery of teaching and training however the education team has adapted teaching methods in order to ensure the continuation of educational opportunities for the whole Multi-disciplinary team. There has been much more use of technology enhanced learning. TEAMs has become the platform for the delivery of a number of teaching sessions both formal programme specific and local teaching. In the latter half of 2022 there are plans to move medical education back into the Gilbert Bain Hospital site (this had to move off site due to space being used to host the green pathway and then day case patients).

Pre- pandemic - in remote and rural areas the access and the quality of link to remote teaching used to be poor as the hosting sites often did not have the expertise to teach remotely and the platforms used such as VC links often did not work. Educators often did not have the expertise to keep remote learners engaged with the teaching sessions

Benefits of technology enhance learning for remote and rural sites:

- The use of TEAMs for linking into programme specific teaching is better than the VC link that required a bridge connection
- The interactive nature of TEAMs teaching with the use the chat function is helpful
- Host sites are better educated on the needs of remote learners

1.15 How do you ensure there is a balance between providing services and accessing educational and training opportunities?
The Medical Education Governance Group has the responsibility to ensure that there is a good balance between service provision and education and training opportunities: • The agenda at the MEGG is split into operational, education and strategic discussions • Thought is given to rota design in that rotas are individualised to reflect the programme specific educational requirements of the trainee: o Surgical trainees have built in rota opportunity to attend theatre, o IMTs have clinics built into their rota and o GPStR's GP Practice placements o Foundation doctors are provided with taster days/sessions • Junior doctor representation on the MEGG • Junior doctor forum • Care is taken to fill any unfilled post as we understand the knock-on effect this can have on the educational opportunities for trainees • Regular monitoring of the rota is undertaken to ensure that it is working time compliant

2 Sign-off

Form completed by	Role	Signature	Date
Pauline Wilson	Director of Medical Education	Pauline Wilson	13/06/2022

Scotland Deanery

Director of Medical Education Report

NHS Board	Shetland			
Responsible Board Officer	Dr Kirsty Brightwell			
Director of Medical Education	Dr Pauline Wilson			
Reporting Period	**From**	August 2020	**To**	July 2021

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Theresa Savage at Theresa.Savage@nhs.scot

Please complete and return to Theresa.Savage@nhs.scot by **16th August 2021.**

1: Undergraduate Medical Education: Quality Report

Key to survey results

Undergraduate Survey (UG)*

Key	
R	Score less than 0
A	Score 0 to less than 0.55
W	Score 0.55 to less than 1.55
G	Score more than or equal to 1.55
	No results available
▲	Better result than last year
▼	Worse result than last year
▬	Same result as last year

*This report utilises data from the Scottish Student Evaluation Survey. Results are only provided where there are at least five responses. "Number of respondents" is the total responses received; the number of responses received for some questions may be significantly fewer. “Possible responses” is the number of students surveyed.

1.1 Site: Gilbert Bain Hospital, Specialty: General (internal) medicine

Undergraduate Survey

School	Specialty	Class Year	Overall Satisfaction	Block Organisation	Treated with Respect	Teaching Delivery	Teaching Quality	Total Teaching	Learning Opportunities	Clinical Experience	Total Experience	Assessment	Feedback	Assessment & Feedback	Learning Support	Pastoral Support	Total Support	IT Equipment	Access to Software	Total IT	Teaching Equipment	Teaching Accommodation	Total Facilities	Number of responses	Possible responses
Aberdeen	Medicine - General Medicine	5	G —	G —		G ▲	G —	G ▲	G —	G —	G —	G —	G —	G —	G —	G —	G —	G —	G ▲	G —	G —	G —	G —	G —	7	8

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

It is pleasing to see that the work put into hosting medical students in Shetland is reflected in the very positive student feedback. This has been achieved by the following:

1. One of our junior doctors is a Clinical Development Fellow (CDF) with 8 hours per week devoted to the medical student teaching and mentoring. This post, set up in collaboration with the University of Aberdeen in 2016, has continued to be pivotal in the delivery of high quality undergraduate teaching. The CDF acts as a mentor the students; a role that the students clearly appreciate. The CDF role is central to the delivery of a start and end of block OSCEs. We have successfully used the OSCEs as a method of teaching and identification of learning need for the students over the 8 week block. The CDF meets regularly with the DME to feedback on any issues with the teaching timetable. The CDF is a member of the Medical Education Governance Group so is a voice for medical students as well as junior doctors – this is helpful in identification of issues and can lead to early resolution of problems.

2. At the start of the block we run an assessment OSCE – this helps us gauge the student's initial needs. Feedback is given and the 8 week teaching timetable is then developed to meet these needs. At the end of the block we run a follow up OSCE – again each student is given individual feedback as well as group feedback.

3. In order to strengthen the multi-disciplinary nature of the teaching experience extra teaching time hours we added to the Specialist Nurses to the teaching team in 2020. This has allowed us to utilise of other health care professionals in the delivery of teaching and training. This continues to provide depth to the teaching programme and has provided both medical students and junior doctors with a better understanding of the skills of the wider clinical team.

4. We continue to work with members of our multi-disciplinary team to ensure they understand the importance of having medical students in Shetland – they have an understanding for the need to contribute to TABs as well as DOPs. Each medical student is encouraged to undertake shifts with the nursing team to ensure they understand the roles other members of the team provide.

5. Students are encouraged to attend wards, clinics and A&E. In Shetland, due to small teams, we use our A&E as our receiving units and students are encouraged to do some weekend and late shifts shadowing the junior doctor team.

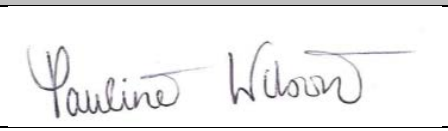
6. Students are provided with the opportunity to have one to one interaction with and teaching by pharmacy colleagues.

7. Although we have had to adapt our teaching methods and styles during the last year due to covid restrictions we have still be able to provide teaching and training:

    - We have used TEAMs for more didactic type teaching
    - We have hosted a TEAMs based OSCE – focusing on history taking skills
    - We have been able to host a socially distanced surgical skills hands on training session (hosted by our surgical Trainee) – students have had the opportunity to learning suturing skills
    - Infection control teaching and use of PPE

8. Our Medical Administrator makes contact with student prior to arriving in Shetland. She sends out a welcome pack with general information on Shetland as well as specific hospital induction information.

2 Sign-off

Form completed by	Role	Signature	Date
Pauline Wilson	DME		21/07/2021

Scotland Deanery

Director of Medical Education Report

NHS Board	Shetland			
Responsible Board Officer	Dr Kirsty Brightwell			
Director of Medical Education	Dr Pauline Wilson			
Reporting Period	**From**	5 August 2020	**To**	3 August 2021

Note to DME: Please complete all sections of the report in relation to the last training year. For assistance, please contact Jill Murray at Jill.Murray@nhs.scot.

Please complete and return to Jill.Murray@nhs.scot by **6 October 2021.**

1. Year in review: 2020-21

1.1 Please outline the main training achievements in your board in the last training year:

1. **Education Resource Centre**
   Background - In November 2018 NHS Shetland opened its onsite Education Centre (Ronas ward). This facility has a large meeting room with VC capacity (to link in with teaching) as well as one large clinical skills space and a dedicated SIM room. This on site facility allowed easier access to teaching and training opportunities for the whole team. The works were funded by NHS Shetland and ACT monies.

   Due to the covid pandemic this teaching space has been re-purposed for "clean green" pathway patients. The loss of this teaching and training space has been a real challenge for the local education team who have had to adapt teaching session in order to continue the local teaching programme. The team has used teaching rooms off-site as well as increased use of TEAMs teaching. We have been pleased to be able to continue high quality and well attended local teaching programme in challenging times.

2. **Medical Administrator Role**
   Background- In January 2020, we successfully recruited a Medical Education Administrator. This continues to be a very important role with the post holder responsible for:
   - Organising local induction of junior doctors
   - Organising local teaching programmes
   - First point of contact for programme specific queries and supporting trainees with TURAS
   - Ensuring that there is support for trainees moving to Shetland
   - Ensuring that rotas and information goes out in a timely manner to trainees
   - Ensuring monitoring of hours is undertaken
   - Provides administration support and action tracker update for the Medical Education Governance Group

   During 2020/21- we have acknowledged the extra pressures that covid has brought to the whole team including the junior doctors. The medical administrator has provided pastoral support to trainees as well as organising what has become a much more complex induction programme. The junior doctors appreciate the support provided by the medical administrator.

3. **Rural Boot Camp (held in Inverness)**.
   Backgorund - NHS Shetland has continued to support the Rural Boot Camp for foundation doctors. The feedback from the trainees has been very positive, in that they feel better equipped for a post in remote and rural hospitals. There is a focus on non-technical skills as well as technical skills across multiple systems and specialties. There are simulated sessions demonstrating the management of acute scenarios, including myocardial infarction and trauma.

During Covid the format/structure of the Boot Camp has changed – a limited number of trainees attend in person with others joining virtually via TEAMs. An instructor has been assigned to the trainees attending virtually in order to discuss what is happening in the simulation sessions.

4. **Utilisation of other health care professionals** in the delivery of teaching and training. Due to the small numbers of medical staff NHS Shetland has been using the wider multi-disciplinary team in the provision of teaching and training. This has provided a depth to the teaching and has provided both medical students and junior doctors with an understanding of the skills of the wider clinical team.

5. **Clinical Development Fellows.** NHS Shetland continues to fund two CDF posts. Balancing service provision with their own educational development, the service delivery and training involvement from CDFs has been of great benefit to NHS Shetland. These additional post allow us to have fully compliant rotas and allow other trainees time to achieve programme specific curriculum requirements- such as IMT attendance at clinics. The CDFs are responsible for pulling together the local teaching programme and this has resulted in improved organisation of the teaching sessions as well as improving trainee's attendance at departmental teaching. The CDFs attend the Medical Education Governance Group representing the medical students and other junior doctors.

6. **Surgical trainee** – in August 2020 Shetland was allocated a surgical trainee. The feedback from the trainees in post has been very positive. Trainees are reporting:
    - Excellent one to one supervision by consultant surgeons
    - Good allocation of time in theatre and clinics
    - Excellent portfolio opportunities.

    The surgical trainees have established a Shetland Surgical Skills programme- these session have been run by the trainees for more juniors members of the team and medical students on things such as suturing skills.

7. **Anesthetics ST6** – In August 2020 we were delighted to host a Senior Clinical Fellow in Remote and Rural Anaesthesia as part of the remote and rural anesthetics fellowship. (This post brings together many facets of medical practice utilised by those practising anaesthesia in remote settings where tertiary care is not locally available. It covers all learning outcomes in the RCoA curriculum for training in remote and rural anaesthesia).

1.2 Please highlight any sites where you have identified good practice	
Site	**Details about good practice**
Gilbert Bain Hospital	Trainee's rotas reflect their programme specific requirements. Though is given to rota design in order to allow trainees to complete their curriculum requirements.
Rural Track GP programme	NHS Shetland continues to host the rural tract training programme where trainees complete all of their GP training on Island. This training programme over the last few years has seen a number of trainees stay on in Shetland post CCT and has been a real benefit for local GP recruitment.
Medical Educational Governance	The Medical Educational Governance Group continues to meet every month. The input to the group from junior doctor representatives has proved invaluable in identification of any issues and has allowed for has allowed early resolution of problems and a team based approach to solutions. The governance group is responsible for operational and educational requirements of hosting junior doctors. It allows for a system wide approach with tangible solutions to problems that could either affect service provision or training. The membership of the group includes representation from clinical and education supervisors, medical management, Executive Management Team, finance, nursing and administration.
Surgical Trainees	In August 2020 Shetland was allocated a surgical trainee. Work was undertaken by the surgical team to ensure that NHS Shetland could meet the programme specific requirements of a surgical trainee. The feedback from the 2 trainees has been very positive. Trainees are reporting: • Excellent one to one supervision by consultant surgeons • Good allocation of time in theatre and clinics • Excellent portfolio opportunities. • Opportunity to see acute unselected surgical patients in A&E The surgical trainees have established a Shetland Surgical Skills programme- these session have been run by the trainees for more juniors members of the team and medical students on things such as suturing skills.

Ethics Committee	NHS Shetland has establish an ethics committee. A junior doctor is invited to be part of the committee. This has been welcomed by the more senior trainees as it stratifies certain parts of their curriculum.

1.3 Please outline the main issues that your board has faced in the last training year:

- There is only one substantive medical consultant responsible for the Educational Supervision of all the medical department trainees. There is a recognised need for recruitment of substantive post holders to share the administrative workload involved in supervision.

- In March 2019, due to Covid-19 pandemic NHS Shetland, like other hospitals, has to reconfigure patient pathways at short notice. In order to facilitate “clean green surgical pathways” the teaching and training center was reconfigured into working clinical space. This has resulted the loss of a dedicated on site teaching and training space. This is a challenge in terms of teaching and training in already difficult times. NHS Shetland has identified off site teaching and training space and clinical simulation rooms have been set up and are ready to use.

1.4 Please outline any new issues that your board is likely to face in the coming training year(s)

- One of our major challenges is going to be the provision of high quality education with the continued loss of our dedicated on site teaching site.

- Reliance on locum and rotational consultant post in the medical team creates an ongoing challenge with regards the burden of providing Education Supervision to medical trainees – FY1/ FY2/ IMT1 and IMT2.

- In order to continue to meet the programme specific requirements of trainees as well as run a working time compliant rota there is a need for NHS Shetland to fund LAS and CDF posts. Rural areas have a disproportionate requirement for non-training grade doctors.

- The rural tract training programme in Shetland has been a real success with high quality GP trainees undertaking the scheme and then settling to work in general practice in Shetland. This programme is in jeopardy as a number of GP trainers near retirement.

1.5 Please identify any sites that should be considered for a visit	
Site	**Reason why a visit may be necessary**
NONE	

1.6 Is medical education and training (MET) a standing item on the agenda of the Health Board (HB)?

- Medical Educational Governance Group's action plan is sent to the Clinical and Professional Governance Committee, which is chaired by a non-executive Board member.
- Acute Services Director and Medical Director are members of the Medical Education Governance Group.
- The UG and PG reports are included in the Medical Directors annual board report.

1.7 Is there a non-executive board member with responsibility for MET?

- The chair of the Clinical and Professional Governance Committee has responsibility for providing the Board with assurances regarding governance as a whole and this includes Medical Education and Training.

1.8 If you answered 'No' to questions 1.6 and/or 1.7, how are education and training issues raised with the HB?

1.9 Describe the quality control activities in relation to MET that have been undertaken by your HB in this training year?

- Medical Education Governance Group (MEGG) meets once a month
- Trainee forums are held regularly
- Trainee representative's sit on the Medical Education Governance Group.
- Trainees meet the Medical Director at induction and are encourage to feedback any concerns/issues
- RAG data is discussed at MEGG and at consultant group
- Feedback from training is collected and informs changes to training content etc.

1.10 Are there forums within your HB whereby senior officers (CEO, MD) or site-based senior clinical management have regular, scheduled meetings with trainee doctors to discuss their training and receive feedback? Please provide full details.

- Director of Medical Education meets with all trainees at induction. The Medical Director (MD) offers the juniors the opportunity to spend time with the MD in order to understand the importance of medical leadership within the organisation. The MD also outlines NHS Shetland procedures for escalation of concerns.
- The DME is one of the small team of clinicians based at the Gilbert Bain Hospital. This allows the DME to keep in regular contact with all the medical students and junior doctors.
- All Educational Supervisors are encouraged to have a mid-way through meeting with trainees in addition to the initial and end of block meetings
- There is junior doctor representation on the Medical Education Governance Group.

1.11 At each site, how many DATIX submissions have been made by trainee doctors within this training year?

Site	Unit/Specialty	Number of DATIX	What are the mechanisms in place for trainees to receive feedback on their submissions?
Gilbert Bain Hospital	Medical/Surgical/anaesthetics	**3**	**Learning summaries are sent to trainees**
Lerwick Health Centre	GP Training	**1**	
Psychiatry	GP Training	**0**	

1.12 At each site, how many trainee doctors have been involved in an SAE?

Site	Unit/Specialty	Number of SAE	Was the Deanery notified and involved in the follow up?
Gilbert Bain Hospital	Medical and Surgical	None	
Lerwick Health Centre	GP Training	None	
Psychiatry	GP Training	None	

1.13 At each site, how many trainee doctors have required 'reasonable adjustments' to their training in relation to a declared disability?	
Site	**Number of trainees**
Gilbert Bain Hospital	None
Lerwick Health Centre	None
Psychiatry	None
1.14 Have you had any external reviews that have impacted on training? Please provide full details, e.g. GMC / HIS etc..	
Details of external review:	**DME comment required:**
NONE	

2. Training Quality Lead Funding Report for 2020/2021 Financial Year

2.1 Financial Breakdown of Use of TQL Funding:

Funded Staff Positions/Sessions	Amount: Financial Year 20/21	Projected Amount: Financial Year 21/22	Projected Amount: Financial Year 22/23
NONE			

Other Expenditure of TQL Funding: Please Specify	Amount: Financial Year 20/21	Projected Amount: Financial Year 21/22	Projected Amount: Financial Year 22/23
NONE			

2.2 Please provide information relating to the objectives for the use of TQL funding:

	Outline the systems, structures, personnel and events that have been put in place to deliver this	Outline the systems, structures and personnel you use to monitor the effectiveness and quality of this delivery	Highlight what has changed since the previous 2019/20 report	Describe any planned changes over 2021-22
1. Successfully deliver against GMC standards	Each trainee has a named Educational Supervisor responsible for the trainee during their placement. There is an Undergraduate lead for Medicine and Surgery. They are responsible for the medical students during their placements. Educational Supervisors and Clinical Supervisors have undertaken appropriate training as stipulated by the GMC. The Director of Medical Education chairs the Medical Educational Governance group (MEGG). The action plan from the MEGG goes to the Clinical and professional Governance Committee, which is a sub-committee of the Board and is chaired by a non-executive director.	Educational Supervisors ensure the trainees they are responsible for complete their on line training portfolios and meet the curricular requirements. The MEGG meets monthly to review both operational and educational matters pertaining to trainers, trainees and medical students. The group is also responsible for monitoring feedback data and any action plans.	Nothing	

2. Support Deanery Visits and manage the timely return on information as required for quality management purposes e.g. NTS, PSI, LEP report, visit action plans	The Director of Medical Education (DME) and the Medical Director (MD) are responsible for facilitating any Deanery visits. They are also responsible for timely return of information required for quality management purposes.	The DME along with the MD will review the survey data. The DME is responsible for collating the data and communicating this to trainers and the Medical Educational Governance Group. The MEGG is responsible for monitoring any action plans.	Jan 2020- a medical administrator was appointed. Funding for this role is part ACT funding and part NHS Shetland finding	
3. Provide pathways for delivery of information to trainees.	Pre- induction information sent out. Formal on site induction day. Written information provided. Start of block meetings with Educational Supervisors. During the block emails sent regarding teaching/training events as well as general block specific information.	Start of block meeting with Educational Supervisors (ES). This is recorded along with a personal development plan in e-portfolio. ES then meets the trainee's mid-block and at the end of each block to complete e-portfolios. NHS Shetland – weekly newsletter goes out to all staff. Weekly teaching programme updates to all junior doctors- local and programme specific teaching	A medical administrator has been in post since 2020- this has helped with the dissemination of information to trainees.	
4. Organisation of hospital induction and documentation of attendance	FY1 shadowing/induction - this covers the requirements as set out in the directive on FY1 induction. There is an all-day induction on arrival. As Shetland has only one middle grade surgeon careful thought has to be given with regards the	The FY1 is provided with a structured shadowing timetable and a Shadowing log book that is required to be signed off. The Educational Supervisor reviews the log book at the start of block meeting. All junior doctors have NHS Shetland induction on arrival.	A medical administrator has been in post since Jan 2020- this post is essential for the organisation of the induction and orientation.	

	mitigation of risk at changeover. If a doctor joins the organisation late a bespoke day induction is pulled together for them.			
5. Support effective departmental induction and documentation of attendance	There are specific slots in the induction day for trainees to meet with the teams they will work with. This includes departmental orientation and familiarisation with departmental procedures and guidelines. NHS Shetland provide faculty for the Rural Boot camp, where foundation trainees due to work in rural general hospitals are given the opportunity to have practical teaching and training. This is held in Inverness three times a year. The boot camp covers many of the common scenarios that trainees might face for the first time in a remote and rural setting. It is a bespoke programme that better equips trainees for rural practice.	Each department retains responsibility for departmental specific induction. The induction timetable is co-ordinated by the medical administrator. Feedback from the rural Boot Camp is collated by the team in Inverness. The feedback has allowed for closer refinement of the programme to meet the trainees needs.	There is a section in induction on managing paediatric patients. Each trainee is invited to a half day paediatric training session run by the anesthetics department.	
6. Ensure compliance with and documentation of appropriate Faculty development for Clinical	Clinical and Educational Supervisors have undertaken Role of the Trainer training.	Monitored by the Medical Director and is part of the appraisal and revalidation	Two GPs have completed ROT training and have	

and Educational Supervisors	Documentation on SOAR.		become accredited Educational Supervisors.	
7. Provide local monitoring and management of doctors in difficulty	The Educational Supervisor for the trainee retains the responsibility for the management of a trainee in difficultly with help and advice from the Medical Director and DME as appropriate. The Training Programme Director (TPD) may be consulted.	The Educational Supervisor keeps a log of the interviews/meetings with the trainee. An action plan is put in place. If this requires a change in working practice the DME and MD would be made aware. The TPD would be consulted. If the needs of the trainee cannot be met in Shetland or more remedial help is required it may be decided in conjunction with the TPD to move the trainee back to the larger teaching hospital.		
8. Facilitating provision of training on work placed based assessment for all staff involved.	Each Educational Supervisor and Clinical Supervisor is familiar with the work place based assessment process and the systems used to record this. Senior nurses & supervising pharmacists also complete work place based assessments. They are familiar with the methodology behind this as they also have profession specific trainees to supervise with similar requirements.	Any updates on e-portfolio activities should come via the training programme director. The Medical Educational Governance Group monitors any changes.	NHS Shetland has its first IMT3 starting in August 2021. During 2020/21 preparatory work was undertaken in order for NHS Shetland to host this grade of doctor and understand the curricular requirements. NHS Grampian TPD had an update session on the new ITM programme. This was available by TEAMs so NHS Shetland were able to be part of the update on the programme and assessments required.	

9. Providing training and updates on e-portfolio activities	The DME meets with other DMEs and attends educational meetings. Training Programme Director updates to educational supervisors.	Any updates on e-portfolio activities should come via the Training Programme Director. The Medical Educational Governance Group should then monitor any changes.	The use of TEAMs digital platform has allowed for better and timely dissemination of information to rural educational supervisors. Virtual meetings held in a better structured forum such as TEAMs has been of benefit to rural education teams.	
10. Provide a local focus for careers advice	The Educational supervisor should identify the career aspirations of the trainee at the induction interview. Trainees have some floating days built into their rotas. They can use this time for quality improvement work or audit. Some trainees have used this opportunity to sit in with visiting consultant or do GP taster days.	The Educational Supervisor on identifying the career aspirations of the trainee aids them in identification of a suitable Quality improvement Project. A QIP forms part of the trainee's e-portfolio log. A high proportion of GP trainees are keen to make Shetland their permanent home. This is testament to the commitment of the local trainers and the support from the GP Training Director, who has help support bespoke training schemes for Island GP trainees.		
11. Provide a local contact for educational research activities	The Educational Supervisor identifies either an audit or a quality improvement project with each trainee. The trainee is then directed to the audit officer and a project outline document is completed and the project title, aims and methods are captured on a spreadsheet.	The audit or QIP is captured and included in the ward governance action plan. On completion of the audit/QIP a findings document is produced or a presentation is made. This then goes back to the audit officer to record.	.	.

12. Provide local advocacy for concerns raised by trainees.	The trainees are encouraged to approach their Educational Supervisor with any concerns. If they feel they cannot do this then they are encouraged to contact the DME or Medical Director. Each trainee can also contact their Training Programme Director directly. Trainees are made aware they can contact Human Resources or Occupational Health. Our local Chaplin also offers pastoral support and care to all staff and this included trainees and medical students. CDF doctors are members of the Medical Education Governance Group and act as advocates for other junior doctors.	Educational Supervisors meet with trainees throughout the block formally at three points during the block as well as informally as part of the day to day work. As the Educational Supervisors are visible they tend to know what is happening and if any concerns being raised. Trainees can also feedback anonymously via the NTS, STS and the GMC survey. Monitor through Medical Education Governance Group.	Covid pandemic has meant we have been unable to run in person trainee forums. Online trainee forums are unpopular.	To reinstate in person trainee forums as and when the covid restrictions allow.
13. Ensure accountability at Board level for performance in the delivery of PGMET.	The DME is the chair of the Medical Education Governance Group. Executive managers are members of the Medial Education Governance Group and are sited on operational and educational	The DME chairs the medial Education Governance group, which in turn reports to the Clinical and Professional Governance Committee, via the Joint Governance group. The Clinical and Professional Governance Committee is a sub-committee of the Board		

	matters related to medical students and trainees. The annual DME report goes to the Board via the MD.	is chaired by a non-executive director.		
14. Provide to the Board regular reports on PGMET Quality Management data including GMC NTS, PSI & NES QM data including reports of QM visits highlighting strengths & weaknesses of training in LEPs in the Board area.	The DME report which covers PGMET, Quality Management data goes to the Board. The report covers the strengths and weakness of the Local Educator Provider. It also identifies the resources required to provide high quality education.	The DME chairs the medial Education Governance group, which in turn reports to the Clinical and Professional Governance Committee, via the Joint Governance group. The Clinical and Professional Governance Committee is a sub-committee of the Board is chaired by a Non-executive Director.		
Any other use made of TQL funding				

3 Postgraduate Medical Education: Quality Report

Key to survey results

Scottish Training Survey (STS)

Key	
R	Low Outlier - well below the national benchmark group average
G	High Outlier – performing well for this indicator
P	Potential Low Outlier - slightly below the national benchmark group average
L	Potential High Outlier - slightly above the national benchmark group average
W	Near Average
▲	Significantly better result than last year**
▼	Significantly worse result than last year**
—	No significant change from last year*
	No data available
	No Data

** A significant change in the mean score is indicated by these arrows rather than a change in outcome.

GMC National Training Survey (NTS)

Key	
R	Result is below the national mean and in the bottom quartile nationally
G	Result is above the national mean and in the top quartile nationally
P	Result is in the bottom quartile but not outside 95% confidence limits of the mean
L	Result is in the top quartile but not outside 95% confidence limits of the mean
W	Results is in the inter-quartile range
▲	Better result than last year
▼	Worse result than last year
—	Same result as last year
	No flag / no result available for last year

No Aggregated data is available this year

3.1 Departments in the bottom 2% for that Specialty

None

3.2 Departments in the top 2% for that Specialty

3.2.1 Site: Gilbert Bain Hospital, Specialty: Acute Internal Medicine

Identified by: STS Level High Performers list (aggregated high scores for specialty)

GMC NTS (Trainee)

Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Curriculum Coverage	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
All Trainees																				<3

Scottish Training Survey

Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Work Load	N
All Trainees								3
All Trainees	G	W	W	L	G	W	W	(5 aggregated)
IMT								3
IMT	G	L	G	G	G	W	W	(5 aggregated)

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

FY1 – shadow booklet developed which aids staff in helping the foundation doctors achieve outcomes during shadowing week.

Island Medics handbook sent out to all doctors prior to arrival – information on post and Shetland.

Rota master emails all new doctors prior to starting work in Shetland to see if any important leave requests.

Rota is generally provided 6 weeks prior to placements.

We have employed CDFs to ensure that trainees rotas are compliant with working time directive and that we can meet the curriculum requirements.

Trainee's forum with voice into Medical Education Governance Group vis trainee representatives.

Structured and targeted induction for all new starts.

Team is supportive of trainee's requests for e-portfolio week based assessments- we are often commended by trainees that it is easier to get consultant to help with this in Shetland.

3.2.2 Site: Gilbert Bain Hospital, Specialty: General (Internal) Medicine

Identified by: STS Level High Performers list (number of green flags and significantly high for specialty) and STS Post High Performers list (number of green flags and significantly high for specialty)

GMC NTS (Trainee)

Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Curriculum Coverage	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
All Trainees			y						y		y		y			y				<3

Scottish Training Survey

Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Work Load	N
All Trainees	G—	G▲	G▲	G—	G▲	W—	G—	7
Foundation	G	G	G	G	G	W	G	6
GPST								1
GPST								(2 aggregated)

GMC Trainer Survey

Specialty	Curriculum Coverage	Educational Governance	Handover	Overall Satisfaction	Resources for trainers	Rota Design	Support for trainers	Supportive environment	Time for training	Trainer Development	Work Load	Response rate
General (internal) medicine												100%

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

Island Medics handbook sent out to all doctors prior to arrival – information on post and Shetland.

Rota master emails all new doctors prior to starting work in Shetland to see if any important leave requests.

Rota is generally provided 6 weeks prior to placements.

We have employed CDFs to ensure that trainees rotas are compliant with working time directive and that we can meet the curriculum requirements.

Trainee's forum with voice into Medical Education Governance Group vis trainee representatives.

Structured and targeted induction for all new starts.

Team is supportive of trainee's requests for e-portfolio week based assessments- we are often commended by trainees that it is easier to get consultant to help with this in Shetland.

3.2.3 Site: Gilbert Bain Hospital, Specialty: General Surgery

Identified by: STS Post High Performers list (significantly high for specialty)

Scottish Training Survey

Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Work Load	N
All Trainees	G	G	G	G	G	G	G	5
Core								2
Core								(2 aggregated)
Foundation								2
Foundation	W	L	W	W	G	W	L	(5 aggregated)
GPST								1
GPST								(1 aggregated)

GMC Trainer Survey

Specialty	Curriculum Coverage	Educational Governance	Handover	Overall Satisfaction	Resources for trainers	Rota Design	Support for trainers	Supportive environment	Time for training	Trainer Development	Work Load	Response rate
General surgery												67%

DME Comment Required: e.g. Do outliers relate to a known issue or good practice? If not, can they be explained? What is the good practice in place? Can it be shared? What are the actions in place to resolve known issues?

Island Medics handbook sent out to all doctors prior to arrival – information on post and Shetland.

Rota master emails all new doctors prior to starting work in Shetland to see if any important leave requests.

Rota is generally provided 6 weeks prior to placements.

We have employed CDFs to ensure that trainees rotas are compliant with working time directive and that we can meet the curriculum requirements.

Trainee's forum with voice into Medical Education Governance Group vis trainee representatives.

Structured and targeted induction for all new starts.

Team is supportive of trainee's requests for e-portfolio week based assessments- we are often commended by trainees that it is easier to get consultant to help with this in Shetland.

In August 2020 NHS Shetland started hosting surgical trainees. Preparatory work was undertaken by the team to ensure that curriculum and supervision requirements could be met. During 2020/21 the post was kept under review to ensure that requirements were being met. The two post holders provided feedback on the placement – feedback was positive.

4 Sign-off

Form completed by	Role	Signature	Date
Dr Pauline Wilson	Director of Medical Education		06/09/2021

Appendix 1. NTS Data for departments not on Triage/High Performers lists

Site	Programme Group/ Specialty	Level	Adequate Experience	Clinical Supervision	Clinical Supervision out of hours	Curriculum Coverage	Educational Governance	Educational Supervision	Facilities	Feedback	Handover	Induction	Local Teaching	Overall Satisfaction	Regional Teaching	Reporting systems	Rota Design	Study Leave	Supportive environment	Teamwork	Workload	N
Gilbert Bain Hospital - Z102H	Internal Medicine Training Stage One	IMT																				<3
Gilbert Bain Hospital - Z102H	Medicine F1	F1			y						y		y		y			y				<3
Lerwick Health Centre - 39091	General Practice	All Trainees									y						y					<3

Appendix 2. NTS Trainer Data for departments not on Triage/High Performers lists

No data.

Appendix 3. STS Data for departments not on Triage/High Performers lists

Site	Specialty	Level	Clinical Supervision	Educational Environment	Handover	Induction	Teaching	Team Culture	Workload	N
Gilbert Bain Hospital	General Psychiatry	All Trainees								1
Gilbert Bain Hospital	General Psychiatry	All Trainees	W	W			W	W	W	(5 aggregated)
Gilbert Bain Hospital	General Psychiatry	GPST								1
Gilbert Bain Hospital	General Psychiatry	GPST	W	W			W	W	W	(5 aggregated)
Lerwick Health Centre	General Practice	All Trainees								3
Lerwick Health Centre	General Practice	All Trainees	W—	W—	W—	W—	W—	W—	R—	(8 aggregated)
Lerwick Health Centre	General Practice	GPST								3
Lerwick Health Centre	General Practice	GPST	W	W	W	W	W	W	P	(7 aggregated)
Levenwick Medical Practice	General Practice	All Trainees								1
Levenwick Medical Practice	General Practice	All Trainees								(1 aggregated)
Levenwick Medical Practice	General Practice	GPST								1
Levenwick Medical Practice	General Practice	GPST								(1 aggregated)