Minutes of the Medicine Specialty Training Board meeting held at 14:00 on Wednesday, 21st February 2024 via Teams

Present: Stephen Glen (Chair), Helen Adamson (HA), Laura Armstrong (LA), Kerri Baker (KB), Karen Cairnduff (KC), Marie Freel (MF), Tom Fradon (TF), Maximillian Groome (MG), Adam Hill (AH), Jen Mackenzie (JMacK), Vhari MacDonald (VMacD), Scott McKinnon (SMcK), Kim Milne (KM), Sarah McNeil (SMcN), Jane Rimer (JR), Claribel Simmons (CS), Marion Slater (MS),

Apologies: Ken Donaldson (KD), Cathy Johnman (CJ), Dawn Mackie (DM), Lynn McCallum (LMcC), Vicky Tallentire (VT), Mun Woo (MW)

Minutes: Zoe Park (ZP) (Minutes)

Item	Item name	Discussion	Agreed/Action
1.	Welcome, apologies and introductions	The Chair welcomed all to the meeting and apologies were noted. The group introduced themselves for the new members of the group.	
2.	Minutes of the Medicine STB held on 29/11/23.	The minutes were accepted as a correct record of the meeting.	**Agreed: minutes accepted as a correct record.**
3.	Review of action points from meeting held on 29/11/23	All action points from the meeting were completed/discussed elsewhere in the agenda.	
4.	Matters arising not elsewhere on the agenda	SMcK noted that there isn't a BMA item on the agenda, SG noted that this would be discussed under the trainee update item.	
5.	Main items of business		
5.1	IM Stage One update: a) Recruitment Update	Paper 2 was circulated before the meeting and JMacK noted the following: • IMT interviews took place in January and went well. Looking at potentially changing IMT interviews going forward to two stations rather than the one. • Highlighted the difficulty across the UK of getting volunteers to take part in the interview process.	

		• Preferences will be opening soon for candidates and offers for IMT will be going out on the 19th March. SG highlighted that this year saw a 42% increase in applications for IM Stage One and this included a 52% increase in CREST applicants which are generally international medical graduates. The self-assessment component of the process which is based on a point system will result in some trainees not getting interviews. An option being discussed at national recruitment is the use of a multi-specialty recruitment assessment (MSRA) but no decisions have been made and trainee representatives at the specialty advisory committee were going to take this back to the trainee committees for comment. SMcK queried if the BMA had been involved in these conversations as their input would be important. KB added that there may be resistance from trainee reps around this as they have been unhappy with MRSA in the past. The better solution is direct evidence checking but accepted that there is not capacity to be able to do this with the large number of applicants. Lastly, SG gave thanks to the recruitment team for organising and the excellent administrative support provided.	**SG agreed to update on this including details of stakeholder consultation.**
	b) IMY2 preferencing	SG noted that the current year two trainees (IMY2) are the last cohort required to preference where they would like to go in year 3. Specialty interest as well as regional basis are taken into consideration whilst trying to balance service demands which can prove challenging. Since last year, trainees who join the training programme are given their placements for the full 3 years of training. The positive aspect of the preferencing process is that it gives good data relating to what trainees will do in the future. Data for this year includes:	

		• 7 trainees across the whole of Scotland plan to leave at the end of IMY2 and 88 will continue into IMY3 (7% compared to 11% last year). • The most common destination for those leaving is Oncology, with the next most common being Combined Infection Training and Dermatology. • 2 trainees opting to become clinical fellows. • The most common specialty preferences after IMT training are Cardiology, Respiratory, Infectious Diseases and Geriatric Medicine. JR noted this data is extremely useful for modelling and planning and queried if there was a way, we could still gather this data in the future. SG agreed that it is a useful survey and would be beneficial to circulate again next year, however, there may be a drop in responses as it won't be compulsory.	
	c) Teaching programme update including trainee conferences	Teaching programme continues to go well, most recently for stage 1 there has been point of care ultrasound session (POCUS), and Cardiology (organised by Gemma McGrory), JR organised a geriatric medicine teaching session and David Carty (DC) organised a Haematology and Oncology session back in January. The National Trainee Conference at Stirling University is coming up and is organised by the trainees themselves, with support from Susan McGeoch (SMcG) and Adam Williamson (AW). The guest speaker will be Andy Elder, President of the Royal College of Physicians (Edinburgh). A wide range of topics that will be covered including outpatient skills, research, quality improvement, clinical leadership and medical education. Alongside these formal sessions there are regular palliative medicine teaching sessions, as well as links to careers events for Oncology and Genitourinary Medicine with mock interview practice sessions available.	
	d) Simulation update	VT couldn't attend the STB, but SG noted that there is currently a quality review project taking place around trainer perceptions of bootcamp and the impact it has had.	
	e) Expansion posts	Approved expansion posts have been allocated as followed:	

		• 3 in North, which includes 2 in Grampian and 1 to Highland. • 6 in the South-East, 2 at St Johns Hospital, Victoria Hospital and the Borders. • 2 in the East, 1 to Forth Valley and 1 to Perth. • 11 in the West, 2 going to Crosshouse, Ayr, Hairmyres, Monklands and Wishaw and 1 going to Dumfries.	
	f) IMY3 standalone recruitment	Paper 3 was circulated to the group before the meeting. Scotland was asked if there was interest in taking part in IMY3 standalone recruitment. This could be beneficial (if successful) as it would allow for filling gaps that are created by those who leave after IMY2 and would be better for rotas in terms of trainee seniority. Currently, it is estimated that there would be around 15 posts that could be included in this.	
5.2	IM Stage Two		
	a) Recruitment update	Paper 4 was circulated before the meeting and JMacK noted the following: • NES run the Gastro interviews on behalf of the UK, and these will be taking place on 18th-22nd March. • Due to industrial action in England, Palliative Medicine interviews have had to be rescheduled and will be taking place in April.	
	b) Stage 2 IMT Leads	KB noted the following: • IMT Stage 2 Leads meeting taking place on 22nd February. • ARCP dates are set and an ARCP guide for trainees will be released. • It has been agreed at a national level that there will be flexibility around how much medicine a trainee has done compared to specialty at this years ARCP. This will be detailed in the guide and guidance will also be given to the ARCP panel members regarding this.	

		• AH will be running an ARCP trainings session on Thursday, 21st March and KB is also planning to run some Stage 2 specific sessions.	
	c) National Education Programme for IM	KB highlighted that this is currently going well, and it has been modelled the IMT Stage 1 programme. There is an increasing emphasis in EDI issues in professional capabilities for consultants, and the plan is to build this into some of the sessions and talks. Additionally, there are ongoing discussions regarding a collaboration with John Hopkins University in the US, where we will provide our talks and programme for them, and they will do the same in return.	
	d) Simulation update	KB recently had discussions with Lindsay Donaldson (LD) regarding simulation and there is a bit of optimism around being able to take to take this forward with someone to take on this role and co-ordinate the centres. There are many pockets of good practice happening in each region, for example KM has developed a programme which is trialling in NoS, but nothing is joined up. Discussions will take place again next month.	
	e) Sport and Exercise Medicine	Paper 5 was circulated before the meeting and discussed by SG before opening up to comments from the group. Discussion arose around the concern of funding sports and exercise medicine, KB highlighted that if the funding was taken from IMT and this is in fact a group 2 specialty then this would cause loss of medical registrars and rota issues. SG informed the group that the aim is for two posts for sports and exercise medicine in Scotland and this has the support of Emma Watson (EW) with a target start of August 2025. An option to fund posts might include expansion in IMT stage 2 trainee numbers. Alternatives might include chronically unfilled post salaries. MF raised the issue of Stage 2 being chronically underfunded, and currently in WoS there is a 15% WTE gap. This has resulted in lobbying for 15 expansion posts which are needed to get back up to full establishment and cover gaps. Although, 2 posts seem reasonable this could still have a negative impact on expansion within Stage 2 if taken from that complement.	

	f) Stroke medicine recruitment	MS agreed with MF and KB regarding funding concerns, and if this was to be supported by expansion but not at the detriment of Stage 2. Additionally, MS queried whether there was an unmet patient need for this like there are in other areas such as stroke, respiratory and remote and rural. SG advised that SEM includes themes to reduce hospitalisation and to improve the physical health of the population. The specialty is not just about elite athletes. The group agreed that they were generally supportive, but some members felt that there may be other ways to provide support to the ageing population and improve unmet patient needs. There is a proposal to create stroke medicine and general medicine posts within Scotland. This would be a three-year Stage 2 programme, with two years being in general medicine and one year being in stroke medicine either in year 2 or 3. SG, MS and AH highlighted that there is an evident demand for stroke physicians. Currently, trainees can apply for a stroke fellowship for up to a year and there are 7 of these across Scotland. Issues to be resolved with the proposal included: - Will these new posts be separate from the training that already exists? - Is there a clinical need or demand for them? - How will these be funding when 7 stroke posts are already being funded? MS gave some background to the current situation: • New curriculum means that a number of trainees were getting the opportunity to gain more exposure to stroke medicine within their specialty without gaining a CCT in it. • The 7 stroke posts were retained after the introduction of the new curriculum to give the trainees to option to gain that additional training – which can be 6 months or a year - whilst having more flexible recruitment to the posts. • Funding for these currently comes from geriatric medicine and acute Medicine in EoS.	**SG agreed to present the consensus of the STB discussion.**

	g) Maternal medicine fellowships	• Still unclear if the current pathways to stroke medicine will provide increased numbers of stroke consultants. This model was first presented to the STB two years ago with reasonable confidence that this would increase workforce. • Raised concern about whether there is a need for separate training post if trainees are engaging with the existing arrangements in the new curricula and becoming stroke consultants at the end of training. AH noted that the data would need to be clearer regarding the current neurology and geriatric model within the new curricula before deciding about the posts but that it wouldn't be appropriate to take the funding for these separate posts from specialties in need. However, a benefit of having a separate pathway may be that it widens out access to trainees from different specialties, who may have an interest in stroke medicine. SG concurred that a third route into stroke medicine would be beneficial. Paper 6 was circulated before the meeting and discussed by SG. SG noted that this proposal has come from the maternal medicine sub-group within the Scottish Perinatal Network which is looking for a way to standardise and make it easier to get experience in acute obstetric medicine for doctors from obstetric and medical backgrounds. The following was noted by the members: **AH** • Ongoing discussions and documentation has been received. • Currently, there is no available funding for a fellowship like this. • Has questioned whether there is a service need for this. • There is an overlap with AIM in terms of the specifications that trainees need to gain. • Four posts were originally mentioned, but unclear what data was used to agree on this number and unclear how many posts it would be for Scotland. AH has gone back and asked for further information.	**AH agreed to share data once available with the STB.**

		• Once there is clarity on the service need, this can be discussed again at the STB around innovative ways to fund posts like this. • The idea of a post CCT fellowship that the health boards could fund was discussed but not well received. • Output of jobs at the end of training must also be considered. **MF** • In terms of the data available around the increased rates in maternal mortality there seems to be a genuine need. Evidence suggests that medical issues experienced when pregnant is the cause of this increased mortality. • Equally, there are greater needs in other specialties and if there is no additional funding for this then this shouldn't be funded at the detriment of them. • Within AIM the trainees do have the option to do maternal medicine as specialist skill. • Currently being modelled in England, but still in its infancy. **MS** • Specialised clinics with specialty can address medical issues faced by pregnant women. • Queried if there is evidence or data available for England which would support extra posts like this improves outcomes and that there is an unmet need for this is Scotland. In conclusion, the group felt that there could be a potential need but there needs to be more groundwork done and objectives made clearer. SG thanked the members for the discussion and highlighted the common themes for these three agenda items, where does the funding come from, how do we create salaries and how do we avoid impacting existing training programmes.	
6.	Standing items of business		
6.1	Deanery Issues: a) Quality Update	VMacD gave the following update:	

		• At the most recent MQMG meeting it was agreed that Inverclyde Royal Hospital had been de-escalated from enhanced monitoring and all requirements had been fulfilled. It will now be followed up through the normal processes. • Majority of TPD and DME enquires have now been received and next steps will be fed back next week. • There two upcoming visits for general internal medicine, one to the QEUH in March and one to Ayr in April. • There are also four upcoming action review meetings for Dumfries and Galloway, Wishaw, Lothian Haematology and Glasgow Royal Infirmary over the next few months.	
	b) Training Management i. ARCPs 2024.	LA gave the following update: • TPM currently preparing for the upcoming summer ARCPs and 8 week e-mails will be sent out over the next couple of weeks, alongside SOAR declarations and absence questionnaires. • Still a shortage of IMT Stage 2 panel members for ARCPs and the dates are as 4th, 6th, 11th, and 13th June. Any help from colleagues would be much appreciated. • PYR lists are in the process of being sent to TPDs.	
	ii. Winter ARCPs 23/24	KC highlighted that everything went well with the IMT Stage 1 winter ARCPs.	
	iii. Accelerating Training and exceptional performance guidance	Paper 7 and 8 were circulated to the members before the meeting. SG noted that this guidance has been circulated to the trainees through TPM. The main issue that has been highlighted recently is the need for an appeals process for trainees who receive a successful ARCP outcome but are turned down for accelerated	

		training. The appeals process is already in place for unsuccessful outcomes and SG queried if it would be possible to model a process on this accelerated training. AH noted that it may be better placed as a review rather than an appeal an make it consistent across specialties. Discussion arose around the guidance and the confusion around competency-based vs time in training. SG noted that this is a four-nation agreement but may be discussed at the upcoming SAC.	**LA agree to investigate this and feedback to SG.** **SG agreed to feedback if there any changes.**
	c) Remote and rural rotations	MS has been working in promoting and supporting remote and rural rotations and highlighted that there is tension between trying to keep doctors in training at one base and acknowledging there is a breadth of experience out there which should be supported. MS noted that there needs to be more flexibility across all the regions in Scotland when it comes to remote and rural. Work is being carried out in collecting data across all specialties and Niall MacIntosh has been approached about adding this information to the deanery website.	
6.2	Equality and diversity	Paper 9 was circulated to the members before the meeting for information. STB has been asked to think about if they support trainees having to evidence that they have achieved learning in professional behaviours in EDI, such as bullying and harassment and how do we support them to do so. Consensus from the group was that they would be supportive of this and that it was important as it will be embedded in future consultant careers. KB noted that this is slowly being introduced to IMT Stage 2 trainees via talks and different sessions and they are being asked to evidence by providing their certificate or reflecting on the session. SG highlighted that it would be useful to look at something for Stage 1 which would flow into what will be provided in Stage 2 so that there is a progression.	**SG asked the members to e-mail any thoughts or suggestions and he will collate them on behalf of the STB.**

		MS noted that she has been working with Al Murray (AM) and they have developed a module that they are hopeful will be introduced in March and there are also ongoing discussions around other modules being introduced to TURAS. Additionally, it's important to look at a range of ways to of delivering this training and education to avoid it just becoming a token task.	
6.3	Service (MD) report	Nothing discussed under this item. Representatives not in attendance.	
6.4	DME report	KM noted that the only issue to highlight is that there is an ongoing issue across all health boards with rota banding which is having an impact on finances and well as a health and well-being issue if trainees are not taking breaks. Each health board is tackling this differently but there are ongoing discussions around provided some additional learning around task prioritisation and potentially something integrated into the curricula.	
6.5	Royal College(s) report	SG welcomed CS to the meeting as the new representative alongside David Wilkin (DW). No update for this meeting.	
6.6	Specialty and STC reports a) Specialty and Specialist Doctors (SAS) Report b) Academic Report c) Trainee Report	Nothing discussed under this item. MW not in attendance. No update. SMcK highlighted the following from the BMA: • No update since the last STB regarding industrial action, new contract should be introduced in April 2026. • There has been survey carried out of junior doctors in the UK and what their experience is with MAPs. (Please see attached with minutes) • Meeting has taken place with NES regarding the Scottish Data which SMcK will share when available. (Please see attached with minutes)	**ZP agreed to circulate to the group.**

	d) Lay Member Report e) Medical Specialty TPD List and National Recruitment Leads	SG welcomed HA as the new lay representative for the Medicine STB. Paper 10 was circulated to the members before the meeting for information.	
7.	AOB	There was no other business noted.	
9.	Dates of 2024 meetings:	• Thursday, 16th May 14:00-16:00 • Friday, 23rd August 14:00-16:00 • Wednesday, 27th November 14:00-16:00	