

Minutes and actions arising from the MDRG Meeting held at 10:00 am on Monday, 5th August 2024

Present: Emma Watson (EW) [Chair], Amanda Barber (AB), Ian Colquhoun (IC), Adrian Dalby (ADa), Alan Denison (ADe), Lindsay Donaldson (LD), Nitin Gambhir (NG), Adam Hill (AH), Greg Jones (GJ), Greg Logan (GL) (SCLF), Niall MacIntosh (NMacl), Lynne Meekison (LMeek), Lesley Metcalf (LM), Jill Murray (JM), Lisa Pearson (LP), Jackie Taylor (JT), Alan Young (AY).

Apologies: Helen Freeman (HF), Greg Jones (GJ), Kim Milne (KM), Colin Perry (CP), Marion Slater (MS), Priya Sharma (PS), Andrew Sturrock (AS), Pauline Wilson (PW).

In attendance: Zoe Park (ZP) (Minutes)

Item	Item Name	Discussion
1.	Welcome and Apologies	The Chair welcomed all to the meeting and apologies were noted as above.
2.	Minutes & Actions from the meeting on 10/06/2024 Rolling actions from MDRG 2023/2024	The notes from the 10 th June 2024 MDRG were accepted as an accurate record of the meeting. The rolling actions list was updated and is attached separately.
3.	Declaration of AOB	No AOB was noted by the group.
4.	National Centre for Remote and Rural	PN presented slides which outlined the current phase of the National Centre. (Please see slide attached) The main points were as follows: <ul style="list-style-type: none">• National Centre for Remote and Rural Health and Care has been funded from October 2023 to September 2025.• The main objective is to address some of the disproportionate health inequalities that exist amongst the remote and rural communities.• Work is being carried out over four specific priority areas and programmes.• Relies heavily on collaborative relationships with partners and NES.

		<ul style="list-style-type: none"> • Currently in phase 1 period which focuses on primary care and rural community services, 25% additional funding that was asked for has been received. • Working towards developing phase 2 and 3 which will encompass the priority needs across the whole remote, rural and island workforce. • There are four departments across the scope of the National Centre which are remote and rural specific: leadership and best practice, research and evaluation, recruitment and retention and education and training. • Currently delivering 40 projects which are all aligned to these four pillars. It is essential to ensure that work carried out within these four pillars feed into each other. • Over the next 12 months' work will be carried out in a focused, deliberate priority project approach and looking at work that will have an impact over this period. • Within phase 1 the team will demonstrate impact with partners across all regions as being geographically distributed and not just focused on one of the rural and island geographies. • The team will also ensure that work is being carried out across the whole primary care practice team in a socially accountable way. • This is important as drivers need to come from knowledge and specialist understanding of the different needs within remote and rural community settings across Scotland, ensuring that impact is demonstrated in the most efficient way possible. • The main challenge being faced is ensuring genuine, practical impact across the 24-month period and setting the foundations for the next 3 to 5 years. • Currently there is a stakeholder membership of around 1300 members, which is extremely positive. • It is important to balance the needs and expectations around this deliberate approach on how the phase 1 investment is being used. <p>PN presented a flow chart on the model of deliverables, both short-term and long term. (Please see attached)</p> <ul style="list-style-type: none"> • The short-term aims are the deliverables referred to in phase 1, the 40 projects across 4 areas, designed to have a medium-term impact and lay the foundations for what comes next. • With further investment in long-term deliverables, the aim is to have impacts and make improvements across a wide range of projects. • For example, the work within recruitment and retention has 4 to 5 projects running in collaboration with partners in CWS and Public Health, which hopefully will also yield results within research and evaluation.
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		<p>through different modes such as case studies, evaluating existing work, reporting on deliverables and working to produce a range of products or artifacts that are used as useful pathways.</p> <p>EW gave thanks to PN for presenting and noted that if any members want to link in with the work that has been discussed, they can contact the remote and rural team or PN directly.</p>
5.	Medical ACT Update	<p>ADe noted that there are 5 items to update group on:</p> <ul style="list-style-type: none"> • Regarding the theme of information sharing and transparency, there is now an information sharing document on the Medical ACT website. It showcases how Health Boards (HB) across Scotland have utilised Medical ACT funding. The Medical ACT webpages are complete, and thanks were given to the Medical ACT team for the refreshment. • There is an ongoing stakeholder engagement process, and after the third stakeholder engagement day in March, a monthly bids process was developed with the stakeholders, which was well received. The fourth stakeholder engagement day took place in June and was well attended with over 50 people. • Further discussions around the NES internal audit around Medical ACT have taken place, and we continue to reflect on the positive updates and feedback that has come from this. A meeting is scheduled for next month which will include pharmacy, medical and dental ACT to further discuss and refine the scope of ACT money. • There was a delay with the allocation letters for this financial year which was out with NES control, and there were weekly communications sent to stakeholders regarding the delay in funding allocation from the Scottish Government (SG). Allocation letters were sent to HBs on the 26th June. • Continue to work closely with HBs and medical programmes through various regional ACT working groups. Some examples of recent activity are upgrading sites to increase teaching capacity, supporting and enabling infrastructure for a new medical programme and confirmed funding for 3 NHS Youth Academy senior specialist lead posts to help support increased applications to medical programmes across Scotland. <p>AD concurred with everything ADe included the update.</p> <p>AY added that from a funding perspective the June letter included that there was just over 40 million recurrent funding for Medical ACT and hopefully this will allow next year's funding letter process to be more straightforward, as there will be no waiting for SG confirmation as it will be sitting in NES baseline.</p>
7.	DME Update	Item not discussed. No DMEs in attendance.
8.	SCLF Update	EW noted her thanks to GL and the other SCLFs not in attendance for all the work that has been carried out over the last year.

		<p>GL</p> <ul style="list-style-type: none"> • Gave thanks to the group for the experience over the past year. • Spent the last month tidying up projects. • Continuing with some work alongside LM and ADi on the study leave projects to take back to the appropriate STBs in the coming months. • Working on handing over work to the incoming SCLFs. <p>GL finished by noting his highlights of the last year, one being participating in the study leave project and managing TPD expectations which has been interesting and challenging to be involved in. Secondly, getting to see breadth of work that takes place within NES that you wouldn't normally get to see as a trainee.</p> <p>The group as whole noted that it was a pleasure working with GL and gave thanks for the work that was carried out on all the different projects.</p>
9.	Scottish Government Update	Item not discussed. HF sent apologies for the meeting.
10.	Recruitment and ARCP data	<p>LD informed the group that the ARCP data supplied was out of step with the governance process. This item will be brought back later once it has been through the formal process.</p> <p>The following was noted regarding the Quality and Safety Group meeting:</p> <ul style="list-style-type: none"> • Next meeting will take place on August 21st. • ARCP data is a standing item on the agenda and will be discussed at the August meeting. • LD Gave thanks to LM for putting the data together and noted that a review will take place and look at any signals for potential problems. • Looked at in conjunction with Quality. • Previously, the group looked at resignations and the data around the reasons why people were resigning and from what areas. Work was carried out by LM, ADi and Alice Main (SCLF) and a process has been produced which will be looked at again at the August meeting. • Another piece of work that was being carried out around ARCPs was the use of 'No Reviews' and the reasons why trainees were receiving this outcome. LM has addressed this data, and this will also be discussed at the upcoming meeting, where it will be looked at how to take this forward. • Lastly, there is ongoing work surrounding inter regional transfer and periods of grace.

		EW and LD discussed that this potentially could be brought back to the MDRG meeting on 2 nd September.
15.	Simulation	<p>LD gave the following update to the group:</p> <ul style="list-style-type: none"> • During COVID there was a large amount of money that came to NES to support simulation, as there was an expectation that perhaps simulation would address some of the unmet learning needs during this period. • During this time there were 24 sessions of postgraduate dean time put in place, however, funding has now expired, and this is still included in several job plans. • Funding within NES is currently under significant stress, with significant resource implications. • Simulation needs to be assessed in terms of what it adds to the training programmes and some APGDs have looked at what it is essential for and where it brings value. • An example of this is the HALO work that is being carried out in emergency medicine, which seems to be where simulation needs to be delivered as it meets unmet needs and produces trainees that can do complex procedures. • Simulation is ever changing, it's not just about skills but also about human factors and patient safety. • A paper will be brought to MDAG at the end of August, which will start the conversation about what simulation will look like moving forward. • Invited the group to get in touch with any thoughts or ideas around this. <p>PN queried if there was a standard approach to evaluating any value in the efficiency of a particular simulation piece. LD confirmed that there is not a standardised way to do this as there is huge variation in simulation offerings. LD suggested that it may be useful to link together to see where the evaluation approach may help in this area.</p> <p>NG added that he has had a positive experience with simulation and the impact that it has had on training over the last 12-18 months, particularly with the collaboration of mental health and GP. As well as the work simulation has been involved with in the IMG space and the positive impact it has had.</p> <p>Lastly, LMeeK highlighted that within the SAS programme they have commissioned small pieces of simulation training by some of the sim leads when they have capacity, which has been very well received by SAS doctors who are not on a standard pathway of experience. Simulation perhaps gives them the confidence to do their role on an ongoing basis or even apply these skills to enter training.</p> <p>LD thanked the group for their comments.</p>

16.	AOB	Item not discussed. No AOB noted by the group.
Date of Next Meeting:		<ul style="list-style-type: none">• MDRG - Monday, 2nd September 2024 at 10:00 am (DME Led Agenda)