Minutes of the Medicine Specialty Training Board meeting held at 14:00 on Thursday, 16th May 2024 via Teams

Present: Stephen Glen (Chair), Kerri Baker (KB), Karen Cairnduff (KC), Gillian Carter (GC), Myles Connor (MC), Marie Freel (MF), Adam Hill (AH), Ruth Isherwood (RI), Jen Mackenzie (JMacK), Scott McKinnon (SMcK), Sarah McNeil (SMcN), Jane Rimer (JR), Claribel Simmons (CS), Marion Slater (MS), Mun Woo (MW)

Apologies: Helen Adamson (HA), Dawn Ashley (DA), Laura Armstrong (LS), Maximillian Groome (MG) and Lynn McCallum (LMcC).

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/guest members of the group.	
2.	Minutes of the Medicine STB held on 21/02/24.	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 21/02/24	All action points from the meeting were completed/discussed elsewhere in the agenda.	
4.	Matters arising not elsewhere on the agenda	Nothing was noted by the members.	
5.	Main items of business		
5.1	IM Stage One update: a) Recruitment Update	Paper 2 was circulated before the meeting and JMacK gave the following update: • Late post that was added for stage 1 has now filled. • There are still a lot of appointable candidates if there are any late posts to be added.	

	b) Fluctuations in seniority	SG noted that it was excellent news that stage 1 has filled again and that there was a huge number of applicants this year. There was a bit of controversy around UK applicants struggling to get through the process, which has been discussed at previous STBs, and which is currently being discussed at UK level. Paper 3 was circulated before the meeting and discussed by SG. The following points were highlighted: • When internal medicine started there was roughly a 30% split across the 3 years. • Not everyone progresses from IMY2 to IMY3, more recently this has increased due to trainees moving into group 2 recruitment for specialties such as oncology. • The consequence of this is that there are more gaps to fill and what has happened before is that these posts would be recycled back to IMY1. • However, this leads to a reduction in the year 3 trainees and a large increase in year 1. • This year there was a drop in IMY1 numbers across most regions. • SG proposed to fix numbers at IMY1 and have roughly the same number of posts every year, for example take the total establishment for each year and divide by three. This would allow the yearly establishment to be known and to be relatively predictable. • IMY2 departures can be offered to boards to backfill as a CDF or we can recruit to IMY3 standalone if there are enough candidates. • IMY3 standalone recruitment will start in 2025 and UK forecasts suggest that it will give enough candidates to fill these posts. Majority of applicants expected to be IMG; however, they will need to be at the stage of IMY2 completion stage. • The aim is creating stability over the next few years. SG asked the group for thoughts around fixing intake at IMY1. **MS** • Noted that it is a very welcome approach, particularly within the NoS which was what was envisaged at the planning stage at the beginning of internal medicine.	

		• Would allow for better planning opportunities, particularly within more rural areas. • Would also be welcomed by DME colleagues in NoS. **JR** • Agreed that fixing numbers at IMY1 will help mitigate against some of the fluctuations but advocated for a bit of flexibility around this. • Expressed apprehension around expansion posts and how this will affect availability for funding to be given back to the Health Boards (HB). **SMcK** • Queried whether fixing the numbers and the introduction on IMY3 recruitment may further disadvantage UK applicants who have expressed difficulty with the current recruitment process due to the competitiveness of the number of applications. SG noted that he is expecting in the long term to see a reduction in the number of IMY3 gaps compared to where we are just now, and one of the issues just now is the oscillations that are coming through and the gaps that these create. Additionally, this system will hopefully create a route for UK trainees who have left and want to come back and complete internal medicine. The issue around the current recruitment system is being looked at. MS added that in the NoS there are several trainees who are peripheral to the system who are keen to train and remain in Scotland, and these posts will hopefully be very supportive of that and give them a way back into training. **JMacK** • With regards to the IMY3 pilot, NES have been asked to lead on the recruitment. **KB** • Concurred with the comments made above and noted the opportunity it would give trainees to come back into training.	

		• Agreed with JR that a degree of flexibility is required, particularly within SES and DGHs and would be useful to get agreement around maintaining the long-term option of being able to release salaries to boards going forward. AH confirmed that this unfortunately can't be agreed in advance as we need to wait and see if the IMY3 pilot is successful in August 2025.	
	c) Teaching programme update including trainee conference feedback	Paper 4 was circulated to the members beforehand and the following comments were made by SG: • The comments from the most recent conference held in Stirling had a wave of overwhelming support for face-to-face events such as this. • There is a proposed bid for this conference to continue annually for stage 1, in a face-to-face setting. STB showed their support for this. • QI conference is expected to transfer online as it works quite well in this format. • AH concurred with the support shown around this.	**SG agreed to create an SBAR for AH.**
	d) Simulation update	SG noted on Vicky Tallentire (VT) behalf that the proposal around fixing the numbers for IMY1 would also support the planning element of bootcamp.	
	e) IMY3 gap solutions	Paper 5 was circulated before the meeting for information and gives background to some of the ongoing work being carried out filling gaps and flexibility that is required. Supports the previous discussions that were had around fluctuations.	
	f) IMY3 standalone recruitment	Discussed previously in the meeting.	
5.2	IM Stage Two a) Recruitment update	Paper 2 was circulated before the meeting and the following was noted by JMacK: • Currently working on the report for the SG fill rates and will circulate in due course. • A few specialties haven't filled, and training management are aware and will be feeding this information back to TPDs.	

	b) Stage 2 IMT Leads c) National Education Programme for IM d) Simulation update	• This doesn't seem to be a Scotland specific issue but rather a specialty specific issue. KB gave the following update to the group: • A guide had been produced for ARCPs and thanked those who contributed comments for it. • Securing ARCP panels for this year has been more successful than in previous. • Webinars and educational supervisor training have taken place, which were well attended. • ARCP panel member training is due to take place after the STB meeting. • Feedback around the teaching programme has been positive. • Working with Lindsay Donaldson (LD) to see how the unmet need for simulation can be met and a meeting is due to take place with the DME network. • Potentially may be able to secure charitable funding to support a course for maternal medicine, which would consist of both lecture based and simulation. SG noted his thanks to KB for her hard work as TPD for Stage 1 as she will be moving on to a new role within the Royal College of Edinburgh. Discussed above. Discussed above.	
5.3	Medical specialty developments: a) Palliative medicine – expansion potential	SG welcomed RI to the meeting and gave thanks to her for attending the STB and giving an update. RI presented slides around discussion of expansion posts (Please see attached) and highlighted the following:	

		• Currently experiencing an unprecedented interest in palliative medicine. • Recruitment has recovered recently with a 100% fill rate. • There are 15 posts and 2 expansion posts that were received a few years ago and are funding for the duration of training for the trainees. • LTFT training is prominent within palliative medicine and WTE currently sits at 11.7, 9.3 are in programme and 2.4 is out of programme. • For August 2024, there are 5 substantive posts and 4 of which have already applied to train LTFT. • Causing an increasing impact on palliative medicine rotas and finances. • Currently there are 4 vacant consultant posts as per workforce data. • CESR has always been of a huge importance to palliative medicine with several colleagues pursuing this route, however, this route closes to single accreditation in October. • If palliative medicine was fortunate enough to get an expansion the support would go to Dumfries and Galloway as this is one of the more fragile areas. As well as St Johns Hospice in the South East and Acord Hospice in Renfrewshire, which has never been a training unit for specialty trainees. RI gave thanks for the opportunity to present and share. SG congratulated RI on her success of turning round the recruitment position as well the introduction of the teaching programme. AH noted regarding workforce planning that it may be useful to link in with Colin Tilly (CT) who is able to crunch numbers and do projections for the next 5-10 years and look at how many trainees are need per year. SG confirmed that he will follow up with AH and LD regarding what is expected from the STB this year with regards to expansion bids. Paper 6 was circulated to the members for information and the following update given. **MS**	**SG and AH agreed to follow this up outside the meeting.**

	b) Stroke medicine – recruitment pilot update	• Work has been undertaken which looks at the impact stroke training has on the new curriculum, predominately across acute internal medicine, neurology, and geriatric medicine on our future workforce. • Current projected workforce for stroke medicine suggests that there will be a shortage of 250 programmed activities based on the recommended sessions per hospital over the number of stroke admissions. • NHS England are piloting a three-year GIM CCT programme that might be one of a range of recommendations we could make to ensure that we have a sustainable stroke consultant workforce in Scotland. • In Scotland, there are currently 7 one-year training posts which usually fill successfully with the specialties mentioned above, but any stage 2 trainee can undertake further stroke training. • Since the introduction of the new curriculum in August 2022, all neurology trainees will achieve a CCT in neurology, GIM and a subspecialty CCT in stroke medicine. • Additionally, all acute internal medicine and geriatric medicine trainees can undertake a minimum of three months stroke training, with the option of taking a further three months and complete an additional six months in a standalone post to gain subspecialty CCT. • Ongoing work from the SAC suggests that consultants contributing to stroke rotas will be dropping sessions which will create a shortfall. • The SAC also suggest that most trainees obtaining stroke subspecialty CCT don't contribute to stroke significantly after CCT. • The best-case scenario is that by 2031 50-70 of PAs could be added to stroke capacity if stroke incidence holds constant. • Stroke workforce retention is notoriously poor; therefore, it is important that change is advocated for. • Currently there are stroke posts available in 40% of acute stroke services in England, which could be a worry and lead to trainees / consultants moving away from Scotland. • The current training provision is insufficient, and it is not clear yet if the new provision through the new curriculum will be sufficient. It is important that we	

		prepare for the increased demand and work to increase stroke workforce in Scotland. • In conclusion, a paper will be presented at MDAG in the coming weeks with some recommendations, including consideration of a trial of the GIM CCT programme in Scotland from August 2025. This will require additional funding from Scottish Government or Health Boards as this can't be funded from establishment. (Please wee SBAR attached) **MC** Noted that MS had encapsulated everything above and added the below: • When the initial work was being looked at by Martin Dennis, particularly looking at the rotas required, it was highlighted that it was beneficial having lots of people contributing small amounts of time to a rota rather than fewer numbers with big PAs. • Feedback from the stroke SAC is that the reason for so much attrition comes down to an overstretched workforce, therefore it's essential as a group that we contribute to this. SG gave thanks for both for the update and noted support from the medicine STB.	**MS will circulate SBAR.** **Will feedback when information is available.**
	c) Endoscopy	Paper 7 was circulated before the meeting and discussed by SG: • The paper highlights the issues around the provision of endoscopy training across Scotland and that the fact that the funding model may have to change. • SG circulated to gastroenterology TPDs for their views and comments, which will be put together with the surgical STB and a consensus drawn for NES. • Noted the fixed costs of JAG courses which are set at UK level. SG welcomed comments from the group.	

	d) LTFT recruitment	**KB** • Following on form the point above, noted that it raises issues around how study leave is delivered in Scotland and how far behind we are from England, with regards to how much we can offer and whether this is meeting the trainees needs. SG concurred and highlighted that there is a differences per region in England and study leave is not unlimited. Additionally, noted that at future STB meetings the group will be asked to look at study leave across all medical specialties to describe what the core study leave activities are and which ones are desirable or optional. This is part of a NES wide review of study leave funding. Paper 8 was circulated with describes the variation in LTFT trainee rates across different programmes. MF gave the below update and discussed the proposal that will be sent to MDAG: • Higher specialty trainees in WoS have a 35% LTFT rate, which does fluctuate across specialty. • Highlighted that there is a particular problem trying to manage endocrinology and diabetes which has around 70% of trainees who are LTFT. This figure is getting worse due to increased maternity leave and from August 2024 50% of the programme will be on MAT leave. Of the trainees left in programme all but one will be LTFT. • An SBAR has been drafted and sent to SG and AH, which proposes a possibility of using WTE shortfall to give a temporary uplift due to the exceptional situation. SG noted that the medicine STB supports LTFT recruitment as a principle. The detailed practicalities require further work, and there is a pilot being explored by NHS England JR queried if this will be looked at Scotland wide as the same issue exists within Rheumatology in SES.	**SG agreed to circulate SBAR to APGDs and model a response.**

		AH concurred with the points above and noted that it will be discussed at MDAG in a few weeks and that it would be beneficial to know the areas which would succeed within a pilot.	
	e) Forensic and legal medicine credential	SG noted that paper 9 was circulated for interest as this is being discussed at several STBs, however, may not be relevant to the medicine STB. If there is a medical specialty it may benefit, SG asked the group to feedback.	
	f) Maternal medicine	Paper 10 was circulated before the meeting and the following was noted: **MF** • This work relates to a unique situation in England, where there is a particularly influential lobby group working towards getting funds realised to allow around 12 trainees to take a year OOP and work as maternal medicine fellows. • If England is doing this, should Scotland also follow this model? • Data shows that there is an increased maternal mortality with increasing multimorbidity and complexity. • Was discussed at the last STB where the group felt it was reasonable for trainees to take time out for this but that the issue lay within funding. • Identified that the route may be through the acute medicine training pathway. SG and AH met with Beth Routledge and Mark Strachan last week to discuss further and concluded that the ideal would be for every site in Scotland to have a consultant available with this accreditation to provide acute support prior to directing to more specialised services which generally focus on outpatient care. This may be a more ambitious bid than was originally expected and the group agreed to put together a proposal. AH added that the above was a fair summary and highlighted that the difference between the model in NHS England is that it is more acute rather than outpatient and currently if there is a specialist problem within Scotland you are referred to a specialist which does seem to work but that there is a need in the first 48 hours of care which this accreditation will support.	

	g) Sport and exercise medicine	SG is meeting again with the representatives from the Faculty of Sports and Exercise Medicine after this meeting as they continue to explore how to develop a training programme in Scotland.	
6.	Standing items of business		
6.1	Deanery Issues: a) Quality Update	GC gave the following update: • The Specialty Quality Management Group meeting took place before the STB. • Main discussion was around the restructuring changes withing the quality team. • More information will be available in due course but there will be different quality managers attached to this group and changes to how data is looked at and how things are updated. • There have been two enhanced monitoring visits since the last STB meeting, at QEUH and University Hospital Ayr for general medicine. Both visits saw improvements and currently working of de-escalation of enhanced monitoring at both sites with a serious of follow up meeting. • Ongoing action plan review meetings with various sites over the next six months, including Dumfries and Galloway, University Hospital Wishaw, Forth Valley, Glasgow Royal Infirmary and Raigmore and the Lothian sites for haematology.	
	b) Training Management	The following update was given: **KC** • ARCPs for IM Stage 1 are underway and trainee evidence deadline date is today. • Currently tying up some loose ends from national recruitment. **SMcN** • Highlighted that for the IM Stage 2 ARCPs there has been good engagement and involvement around panels. • Gave thanks to the group for their support in getting people involved.	

6.2	Equality and diversity	Nothing discussed under this item.	
6.3	Service (MD) report	Not Discussed. No representative in attendance.	
6.4	DME report	KM noted that there was nothing further to add under this item.	
6.5	Royal College(s) report	Not discussed. No college representative in attendance.	
6.6	Specialty and STC reports a) Specialty and Specialist Doctors (SAS) Report	Paper 11 is circulated before the meeting and discussed by MW: • This is the SAS CESR portfolio survey that was performed in the first quarter of this year written by SAS APGD Lynne Meekison. • Identified those who are interested in portfolio pathway or who have already engaged in it. As well as asking those who have already been supported through CESR to complete and there was a total of 78 responses. • The largest group who is aiming for medical registration is the medicine specialties at around 37%. • 24% of SAS doctors are actively gathering evidence and 10% have current applications open with GMC. • Five of the SAS doctors who have been supported have been appointed to substantive consultant posts. • One of the main barriers is the insufficient opportunities for placements due to the dual curriculum for some medical specialties. • Currently, the support that is provided is the funding of two 3-month secondments to achieve gaps in competencies, but with dual accreditation most SAS doctors require 12 months of general medicine. • Welcomed advice from the group on how to support senior SAS who are in medical specialties and because of changes are struggling with experience in general medicine.	

		Discussion took place around potential ways this can be supported and funded but taking logistics of meeting curricular competences and benefits to departments into consideration. KB highlighted that it would be good to know who this will affect over the next year and what they need so that the group can try their best to support. KM agreed to take the paper to the next DME meeting for further discussion and invited MW to the meeting to give some background detail. The group agreed that it would be beneficial to have a Scotland wide view on the topic.	**KB and MW agreed to discuss further.** **KM to invite MW to DME meeting.**
	b) Academic Report	Not discussed.	
	c) Trainee Report	SMcK gave the following BMA update: • Hasn't been much progress made with the Scottish Government regarding a pay deal for 23/24 but it is starting to look more promising. • Negotiations are ongoing. • No update on the April 2026 contract introduction. • From a consultant perspective the recent pay offer that has been accepted in England and disparity in pay has impacted the narrative in Scotland. • BMA are holding an engagement event on the 22nd May, which is open to both members and non-members. • MAPs document for safe scope of practice has been published. (See link below) Medical associate professions (MAPs) (bma.org.uk)	
	d) Lay Member Report	Not discussed. No Lay representative in attendance.	
	e) Medical Specialty TPD List and National Recruitment Leads	Please see attached and notify ZP of any changes.	

7.	AOB	There was no other business noted.	
9.	Dates of 2024 meetings:	• Friday, 23rd August 14:00-16:00 • Wednesday, 27th November 14:00-16:00	