Notes of the AICEM STB Meeting held at 09:30, 11th December 2024 via Teams

Present: Russell Duncan [Chair], Laura Armstrong (LA), Kirsteen Brown (KB), Seamus Crumley (SC), Jenifer Duncan (JD), Paul Fettes (PF), Adam Hill (AH), Angela Jenkins (AJ), Bianca Ebtehadj (BE), Calum MacDonald (CMcD), Jen McKenzie (JMcK), Graeme McAlpine (GMcA), Katherine McDowall (KMcD), Alistair McFayden (AMcF), Laura McGregor (LMcG), Thalia Monro-Padayachee (TMP), Jeremy Morton (JM), Hugh Neil (HN), Gemma Roddie (GR), Gary Rodgers (KR), Malcolm Smith (MS), Gillian Pickering (GP) & Graham Wilson (GW)

Apologies: Andrea Baker (AB), Oliver Daly (OD), Jim Foulis (JF), Stephen Friar (SF), Paul Gamble (PG), Judith Joss (JJ), Anoop Kumar (AK), Stephen Lally (SL), Andrew Linton (AL), Mhari MacDonald (MMacD), Cieran McKiernan (CMcK), Catriona McNeil (CMcN), Holly Metcalf (HM), Jeremey Morton (JM), Edward Mellanby (EM), Colin Munro (CM), Alistair Murray (AM), Linzi Peacock (LP), Kenny Pollock (KP), Kenny Rodgers (KR), Malcolm Sim (MS), Ben Slater (BS), Stewart Teece (ST), Claire Vincent (CV) Cameron Weir (CW), Lorna Young (LY) & Neil Young (NY)

Present: Rachel Brand-Smith (RBS)

Item No	Item	Comment	Action
1.	**Welcome & Apologies**	The chair welcomed the following new member: • **Dr Alistair McFayden** – Royal College of Emergency Medicine, EMTA Rep	
2.	**Minutes of meeting held on 05/09/2024**	The following corrections were requested for the 05/09/2024 meeting notes: • **Item 6.1 - Anaesthesia:** Change MRSA to MSRA • **Item 7.2 - Faculty of Intensive Care Medicine:** Change ARCEM to RCEM	**RBS** to correct meeting notes of 05/09/2024
3.	**Action Points from meting 05/09/2024**	See Action Log – December 2025	
4.	**Matters Arising**		
4.1	**Expansion Posts**	AH gave the members a summary regarding expansion post requests:	

		• **Shape of Training Committee:** AH confirmed that TPD expansion posts have been discussed by the Shape of Training committee and submitted to the Scottish Government for consideration. • **Whole Time Equivalent Model:** AH confirmed that NES have requested a move to a Whole Time Equivalent model which would address issues such as Less Than Full Time etc. AH noted that it would take approx. three years to move all specialities to a Whole Time Equivalent model.	
4.2	**Less Than Full Time**		
4.2.1	**Less than Full Time – Pilot Project**	AH gave the members a summary of the proposed LTFT Pilot Project including: • **LTFT Pilot Project:** AH confirmed that less than full time posts will be advertised as part of a pilot project. For example, if a department has a 0.6 gap this can be advertised as a 0.6 post. This is a UK wide project which will involve specialties with high rates of LTFT requests. AH noted that, if adopted, this approach could also address issues related to gaps caused by expansion posts. • **Pilot Project Funding:** JM asked whether there was additional funding for this project. AH confirmed that there was no additional funding, and all activities would be carried out as part of the Whole Time Equivalent project. • **Types of LTFT Posts:** MS asked if all posts would be advertised at 60%. AH confirmed that a variety of percentages could be advertised. AH confirmed that it has been assumed at this stage that most posts will be advertised in Higher level training. • **Pilot Project SOP:** JM asked if a SOP would be developed as part of this project. AH confirmed that a SOP has not been developed however standard HR guidance regarding 0.6 posts can be used in this situation.	

		• **Future of Pilot Project:** GR asked if advertising less than full time posts would definitely go ahead if the pilot project was successful. AH confirmed that this would be the case. RD suggested that adverts should be targeted to areas with rota gaps. • **Board Response:** AH asked if the members would like to take part in this project. RD suggested board members discuss participation and then feedback to the chair. RD stated that he would pass on information to Laura.	**All** members to discuss participation in LTFT pilot project and send responses to LA
4.2.2	**Less than Full Time – Pilot Project – Possible Issues**	Various issues were discussed related to the whole-time equivalent pilot project including: • **Issues with Smaller Specialties:** AH noted that smaller specialties may find it difficult to provide posts for resident doctors moving from less than full time to full time. AH noted however that this may be mitigated by resident doctor turn over. • **Possibility of Discrimination:** MS suggested that advertising less than full time post could be regarded as 'discriminatory' i.e. posts could restrict resident doctor's choices. AH clarified that this was not the case and that other non-training posts are advertised as LTFT. • **Patterns of LTFT Requests:** MS highlighted that levels of less than full time requests vary over typical training periods i.e. there are fewer requests at the start of training and an increase in requests in higher training. MS noted that this may result in some areas having higher rates of less than full time posts which may cause difficulties. AH noted that the pilot would attempt to address these issues. • **Cost of LTFT Requests:** HN raised the issue of less than full time posts costing more in real terms than full time posts. AH stated that this was an acknowledged issue regarding LTFT. • **Move back to Full-Time:** PF asked whether it would be possible for resident doctors to move from less than full time back up to full-time. AH stated that this issue had not been encountered so far however the pilot may provide some information regarding this.	

		• **Possible Alternatives:** GR asked whether slot sharing could be used, for example a 0.6 post can be matched with a 0.4 post. AH confirmed that slot sharing works in England due to a different funding model and this may not work in Scotland. HN also notes that slot sharing may not be appropriate in Scotland due to differences in resident doctor and consultant contracts.	
4.2.3	**Less than Full Time - Definition**	RD asked the board for their definition of Less Than Full Time. Discussions included: • **Issues regarding LTFT:** RD stated that if a resident doctor asks to reduce their hours from 100% to 80%, 80% is calculated on the maximum hours a resident doctor can work i.e. 48 hours. RD however pointed out that some 80% LTFT doctors work 38.4 hours which is equivalent to 90%. This calculation has a knock-on impact for the calculation of banding, breaks etc. • **Calculations LTFT:** GMcA noted that some sites use self-rostering. For example, doctors requesting to work 80% will be asked to work 80% day shift, 80% night shift, 80% education development time etc. GMcA also noted that some less than full time calculations are based on the unique circumstances of some site rotas. • **Pay vs Training Progression:** SC asked if it was possible for resident doctors to be paid at 0.9 but progress at 0.8. RD confirmed that this could be the case and may be viewed as discriminatory by some resident doctors. RD noted that this has additional complications for competency based curriculum models in Emergency Medicine. MS stated that it must be made clear that less than full time doctors do not progress at the same rate as full-time doctors. • **Issues of Discrimination:** RD highlighted that lack of clarity on how less than full time posts are calculated may lead some resident doctors to believe that the practice is discriminatory. LMcG noted that those who CCT on a LTFT contract can enter consultancy posts at a slightly higher level than if they were full time. JM and LMcG noted that many resident doctors were aware of the calculations regarding	**RD** to discuss less than full time calculations and associated issues with TWDS

		less than full time pay. LMcG suggested RD discuss issues with TWDS who deal with resident doctors wishing to move to less than full time. • **Assessment of Rota Issues:** JM highlighted work carried out by Neomi Freeman regarding rota supervisors. JM reported that predicted difficulties faced by rota supervisors attempting to fill rota gaps was slightly less than expected.	
4.3	**STS – Sexual Harassment Survey Results 2024**	Various issues related to the STS Sexual Harassment results including: • **NES Guidance:** RD noted that NES has guidance for TPDs regarding complaints and disclosures etc. on the TURAS website. • **Local Feedback**: MS noted that issues have not been noted local feedback and Quality Management assessments in ICM. MS highlighted however that that the specialty should remain vigilant. RD noted that the GMC survey has included workplace harassment questions for two years and feedback has been received regarding Surgery and Anaesthetics.	
4.4	**NES Study Leave**	Various issues regarding Study Leave were discussed including: • **NES Review:** RD confirmed that the decision regarding overseas study leave has been rescinded and Study Leave is still under review. RD noted that a letter from Anaesthetics (West Region) had been submitted to NES regarding Study Leave budgets. • **Resident Doctors Response:** GR noted that the present Study Leave budget was inadequate. GR suggested that the Study Leave budget should either be increased significantly or the Simulation training programme should be significantly expanded (See Item 5.5).	
4.5	**COPMeD – Guidance on Changes to Programme**	Various issues were discussed regarding the COPMeD guidance including:	

		• **Purpose of Document:** RD noted that this document gives guidance on how to manage resident doctors who want to CCT early. RD noted that this document offered a very broad approach and may have to be adapted for individual specialties. • **Accelerated CCT:** GMcA suggested that the document should clarify that the final decision on whether a resident doctor can CCT early is made by the penultimate ARCP panel. GMcA noted that if a resident doctor wishes to accelerate their CCT date they should start preparing for this approximately one year before their final ARCP. • **Issues related to ICM:** KMcD and GR highlighted that the most critical year for ICM training is the final year and reducing this by approx. three months would be problematic. KMcD confirmed that this has been raised as a concern by ICM Regional Advisors however CC noted that there was not much demand for ICM resident doctors at present. RD suggested that FICM draft their own guidance regarding early CCT. • **Issues related to Anaesthesia:** MS noted that it is straightforward to take account of resident doctor's additional experience at ST4 level however it is difficult to balance early CCT dates in higher training when other issues such as rota demands, training requirements, out of sync doctors etc. have to be taken into consideration. • **Issues related to rotas:** HN highlighted the impact on Service of higher than anticipated numbers of resident doctors CCT-ing early and leaving gaps in Service rotas. • **Issues of Equity:** GR noted that early CCT may be viewed as discriminatory by some resident doctors. CC noted however that an early CCT would benefit resident doctors who are out of sync and would allow them to apply for consultant jobs in August instead of September of the next year.	

		• **Issues of Competency:** KB suggested that the document contain a definition of competency and an outline of who decides resident doctor's competency. RD suggested that this be added to local college guidance.	
4.6	**ICM - Rota Caps**	Various issues related to rota gaps including: • **Rota Cap Issue:** KMcD stated that some resident doctors in the West Region are requiring posts to complete training however some sites are refusing to fund the banding supplement due to financial constraints. KMcD noted that this, coupled with possible changes to LTFT etc., may cause considerable bulges in the number of resident doctors in training. • **Impact on other regions:** RD asked if this was being experienced in other regions. JM stated that this was not occurring in the South-East Region however there have been bottle necks in sub-specialty training. PF stated he would enquire whether this was happening in the East Region. HN noted that this was happening in the Foundation Programme. • **Board Response:** RD suggested that KMcD contact DMEs and health boards for a response. RD noted that the STB must communicate to resident doctors that all doctors have equal rights to training. MS stated that the West Region may require support from NES when communicating with Service and noted that if funding is provided, sites will have to prioritise which resident doctors proceed with training first.	
5.	**Deanery Issues**		
5.1	**Quality Management**	Various issues related to Quality were discussed including: • **Transitional QRPs:** JD confirmed that transitional QRPs had been held in September. JD stated that this allowed the groups to review all the available data that would usually be reviewed by the larger QRP groups.	

		• **Quality Management Letters:** JD confirmed that nineteen Good Practice letters and six Enquiry letters were issued on 01/09/2024. • **Quality Management Group:** JD confirmed that the first Quality Management meeting was held on 01/11/20204. This meeting closed the Action Plan for RAH Emergency Medicine. An Action Plan for RIE Emergency Medicine will be started in February or March 2025. • **Quality Engagement Meeting:** An Engagement meeting will be held with Queen Elizabeth Hospital, Glasgow - Emergency Medicine in April 2025. • **Continuous Assessment Model:** JD confirmed that Quality Management will now move to a continuous assessment cycle and the next assessment will take place in March. • **Outside factors Impacting Patient Safety:** RD noted that some sites are working under very restrictive conditions outwith departments control. RD asked whether Quality took this into consideration. JD confirmed that Quality was aware of this and that the continuous assessment cycle and the use of Action Plan meetings etc. were an attempt to address this. JD noted that continuous assessment allows Quality to intervene at an earlier time and so avoid triggered visits etc.	
5.2	**MDMG**	• RD confirmed that there were no items to discuss	
5.3	**Professional Development**	• RD confirmed that there were no items to discuss	
5.4	**Equality, Diversity & Inclusivity**	• RD confirmed that there were no items to discuss	
5.5	**Simulation Training**	LMcG gave the members the following update regarding the Simulation Programme including:	

		• **APGD Posts:** LMcG confirmed that all the Simulation APGD posts will not have their SLA contracts extended beyond August 2025. EB highlighted that the Simulation APGD roles were vital to sustaining the Simulation Programme. • **New Simulation Posts:** LMcG confirmed that a small number of Simulation cross specialty roles will be advertised in 2025. Discussions are ongoing as to how these posts will be developed. LMcG requested members send her any feedback. • **Future of Simulation Courses:** LMcG and TMP confirmed that funding for courses will be continued, and information related to these courses can be found on the Scottish Deanery website and TURAS. LMcG noted that funding for these courses comes directly from Scottish Government. • **Emergency Medicine Example:** LMcG gave a summary of the Emergency Medicine Simulation programme for 2025. Resident doctors will be given five higher training dates in 2025 which cover subjects such as Facial Trauma, Obstetric & Gynaecological Emergencies etc. • **Issues related to Bootcamps:** LMcG highlighted that the funding for Surgery and Medicine bootcamps comes via a different funding stream. LMcG noted however that other specialties do not have this funding and noted that this may not be an equitable situation. • **Gaps in Funding:** TMP raised the issue of lack of funding for Faculty sessions and job planning. TMP confirmed that this issue has been discussed with Lyndsey Donaldson and she will be sending an e-mail asking TPDs for their feedback on this issue. • **Simulation Programme Cost Benefits:** TMP highlighted cost-savings when in-house training is provided instead of using external training. LMcG highlighted the low cost of training provided by higher training resident doctors. • **Resident Doctors Response:** GR stated that Simulation courses are highly valuable to resident doctor training and lack of funding and support for this was deeply	

		concerning. GR stated that the Simulation Programme should either be made permanent or the study budget significantly expanded. GR confirmed that the Royal College of Anaesthetists have sent a letter to NES outlining these concerns. • **Response from the Board:** RD suggested that the board draft a letter outlining its support for the continuation and/or expansion of the Simulation Programme to be sent to the NES executive team. There was general agreement from the board regarding this. RD stated that he would draft a letter for approval by the members to be sent to Lyndsay Donaldson.	**RD** to draft letter outlining the board support for the Simulation Programme to be sent to the NES Executive team
5.6	**Recruitment**	JMack gave the members the following update regarding Recruitment including: • **CT1 Applications:** JMacK stated that Recruitment have received double the number of applications in 2024 for CT1 than in 2023. JMacK noted however that Level 1 applications have increased for all specialities this year. • **ST4 Applications:** JMacK confirmed that there have been 85 applications for ST4. Because of this one of the ST3 interview days has been converted into a CT1 interview day. • **Emergency Medicine:** JMacK confirmed that Emergency Medicine did not fill this year in Round 3, Level 4.	
6.	**Training Management (Recruitment, ARCPs, Rotations)**		
6.1	**Highlights from TPD Reports**	RD gave a summary of highlights from the various TPD reports including: • **General Observations:** RD noted that there has been a positive response to the recent expansion post bids for all specialties. All specialties have reported low level of Developmental Outcomes. In addition to this, there are ongoing issues regarding Less than Full Time, adoption of the Whole Time Equivalent Model and Study Leave Budget.	

		• **On-site Issues:** Issues regarding on-site issues such as catering and parking have been raised. RD noted that these issues are outwith the control of the board and suggested HN discuss this with DMEs and relevant parties	**HN** to discuss with fellow DMEs and relevant parties' issues related to resident doctors and training sites.
7.	**Royal College Reports**		
7.1	**Royal College of Anaesthetics**	JA gave the members the following update regarding various issues including: • **CT1 Applications:** JA confirmed that there were more than double the number of applications this year for CT1 with a 10:1 ratio. • **Run-Through Training:** JA stated that the college has still not made a decision on which run-through model it will recommend. RD confirmed he would be discussing this issue with the Royal College in February. • **Accelerated CCT:** RD asked whether there had been any discussions regarding college guidance on accelerated CCTs. JA confirmed that no guidance has been drafted yet.	
7.2	**FICM**	• A rep from FICM was not available	
7.3	**Royal College of Emergency Medicine**	GMcA gave the members an update regarding various issues including: • **Curriculum Changes:** GMcA confirmed that some changes to Procedural and Leadership Skills learning outcomes were being considered. GMcA confirmed that information regarding this may be available in the next six to twelve months. • **Trainer Study Day:** GMcA confirmed that a Trainer study day will be held on 14/03/2024.	

		• **Recruitment:** GMcA confirmed that recruitment will happen over February and March next year and consultants have been contacted on how to sign up to interview days. • **Increasing Number of CCT:** GMcA and AMcF noted that there are higher numbers of resident doctors CCT-ing than there were five years ago and there is some anxiety amongst resident doctors about the availability of consultant posts.	
8.	**SAS Report**	• GW stated that GMC Workforce data has indicated that there has been a 75% increase in SAS and locally employed doctors between 2019 and 2023. GW noted that this has a knock on effect on training capacity. GW asked members to direct any SAS doctors with queries to the SAS team.	
9.	**Academic Report**	• An academic rep was not available	
10.	**Trainee Report**	GR gave the members a summary of Resident Doctors issues including: • **Resident Doctors Issues:** GR highlighted general high level of satisfaction with training in Scotland however there are still issues related to training availability in the North Region and on-site issues such as catering and parking. SC confirmed that the BMA is in discussion with sites regarding site facilities. • **Recruitment ICM Numbers:** GR noted that this year's recruitment rate was 56% and asked if this required any further action. RD confirmed that discussions are ongoing regarding this. GMcA and KMcD stated that the low rate was due to Inter Deanery Transfers impacting the North Region. KMcD suggested GR contact her with any concerns. • **Dual Training:** SC stated that resident doctors have raised issues regarding doctor's ability to apply for dual anaesthetics and ICM or ICM and Emergency Medicine. SC highlighted the possibility of a reduced number of training numbers. RD requested SC draft outline of the issue for him and RD will provide a formal response.	**GR** to contact KMcD regarding any issues relating to ICM recruitment **SC** to contact RD regarding issues regarding dual training and reduced training

			numbers for a formal board response
11.	**Lay member Report**	• The Lay rep was not available	
12.	**AOB**	• There were no addition discussion items	
13.	**Date of Next Meeting**	**Dates for 2025:** • 07/02/2025 (09:30 – 11:30) via TEAMS • 22/05/2025 (09:30 – 11:30) via TEAMS • 05/09/2025 (09:30 – 11:30) via TEAMS • 12/12/2025 (09:30 – 11:30) via TEAMS	