Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	11 June 2019
Type of visit	Triggered Programme Visit
Level(s)	ST3+
Specialty(s)	Respiratory Medicine
Programmes:	South East, East and North Deanery Regions

South East Programme:

Board	NHS Lothian	**Hospital**	Royal Infirmary of Edinburgh at Little France Western General Hospital St John's Hospital
Board	NHS Fife	**Hospital**	Victoria Hospital Queen Margaret Hospital
Board	NHS Borders	**Hospital**	Borders General Hospital

East Programme:

Board	NHS Tayside	**Hospital**	Ninewells Hospital Perth Royal Infirmary

North Programme:

Board	NHS Grampian NHS Highland	**Hospital**	Aberdeen Royal Infirmary Raigmore Hospital

Visit panel	
Reem Al-Soufi	Visit Chair – Associate Postgraduate Dean for Quality
Russell Duncan	Quality Lead
David Smith	College Representative
Tom Drake	Lay Representative
Heather Stronach	Quality Improvement Manager
In attendance:	
Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine
Lead Dean/Director	Professor Alastair McLellan
Quality Lead(s)	Dr Reem Al-Soufi Dr Stephen Glen Dr Alan McKenzie
Quality Improvement Manager(s)	Heather Stronach and Alex McCulloch
Unit/Site Information	
Trainers in attendance	16 consultants
Trainees in attendance	14 trainees
Feedback session: Managers in attendance	Training Programme Directors, Directors of Medical Education (or representative)

Date report approved by Lead Visitor	Reem Al-Soufi 15/08/2019

1. Principal issues arising from pre-visit review

The Deanery's scheduled visit programme aims to visit each unit/location delivering training once every 5 years. Following the review of all available information in 2018, including the the General Medical Council's (GMC's) National Training Survey (NTS) for trainees and for trainers, and the Scottish Training Survey (STS), the Deanery's Quality Review Panel decided to trigger a visit to the respiratory medicine programmes across all regions of Scotland.

Due to the scale of training numbers, a separate visit to the West of Scotland took place on 29 May 2019 and the visit report for this is available on the Scotland Deanery's website. A combined visit to the North, East and South East Deanery regions took place on 11 June 2019 and is the basis of this report.

Before the visit, the panel analysed the data available from the GMC's NTS. Programme 3-year trend data illustrated that:

- North region – White flags in most domains for Aberdeen Royal Infirmary with light green flags for handover, supportive environment and curriculum coverage. Raigmore hospital had no data due to number of trainees based in the hospital.
- South East region - White flags in most domains for the Royal Infirmary of Edinburgh with green flags for handover, supportive environment, workload, rota design and a light green flag for reporting systems. Other South East sites had no data.
- East region - White flags in most domains for Ninewells Hospital aside from red flags for regional and local teaching and workload. Overall satisfaction received a red flag in 2016 and 2017, and a light pink flag in 2018. Reporting systems was red in 2016, and changed to a pink in 2017 and to white in 2018. Induction was also observed to have received a pink flag in 2016 and 2017.

The Deanery's STS collects information about the performance of a training post. This is feedback from all cohorts of trainees within respiratory medicine, and may not necessarily reflect the view of registrars. The data suggested that the posts are within the normal ranges of satisfaction, except a red flag for handover and workload, and pink flags for induction and team culture for Ninewells Hospital only.

A Pre-visit Questionnaire (PVQ) was also sent to training registrars approximately 6 weeks prior to the visit and the results were shared with the visiting panel. Broadly summarised, common themes for improvement across all the respiratory medicine programmes from the PVQ were:

- Induction
- Gaps in the rota
- Teaching
- Perceived absence of regular informal feedback
- No perceived learning from adverse incidents (East region only)
- IT resources.

2. Introduction

In the North region of Scotland, trainees spend the first year of their training programme at Raigmore Hospital. This experience is limited to general internal medicine (GIM) only. Following this year, trainees spend most of their time in training at the Aberdeen Royal Infirmary.

In the East regional programme, respiratory medicine training takes place at Ninewells Hospital and trainees can rotate though Perth Royal Infirmary.

In the South East regional programme, trainees rotate through the Royal Infirmary of Edinburgh at Little France, Western General Hospital, St John's Hospital, Borders Hospital, and the Victoria Hospital, Kirkcaldy in Fife.

A summary of the discussions at the visit has been compiled under the headings in section 3 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

3.1 Induction (R1.13)

Deanery South East Region

Trainers: The Training Programme Director (TPD) reported that there is an induction document across all their sites that explains how the respiratory units work and which also details working on call and out of hours. Trainers in the South East region confirmed that face-to-face induction takes place at all sites, is consultant led and trainees will meet with the wider respiratory medicine team such as physiologists and nurse specialists as part of this induction. If a trainee misses induction, they are offered a 1:1 induction at the next available opportunity. Induction materials are also available to access online and trainees regularly update the handbook: Trainers said this works well as often trainees can suggest items that should be included in induction that were not immediately apparent to consultants.

In the South East, the programme is structured with subspecialty areas mapped out at each rotation. For each rotation, trainees are aware what outpatient clinics and procedures they should be able to achieve for the respiratory medicine curriculum. Trainees spend their first year in a district general hospital and indicative numbers about assessments are provided to inform training.

Trainees: All trainees but one in the South East confirmed receiving a face to face induction and having received the written induction materials. One trainee said that they did not immediately receive the induction materials but suggested that this might be because they had rotated there before. They received this information at a later stage.

Deanery East Region

Trainers: The TPD reported that there is a respiratory medicine induction booklet provided to all training grades about the respiratory unit. This is not specifically aimed at specialty training registrars (StRs). Trainers said that their StRs are often local trainees who have already worked at Ninewells Hospital so not much by way of induction to the department is needed. Trainers confirmed that meetings are always set between the StR and their allocated educational supervisor (ES) to provide them with an induction about their training. They will discuss e-portfolio and their specific training needs for the programme. This occurs at Perth Royal Infirmary as well.

Trainers said that their StRs were not routinely involved in updating their handbook but there had not been any new starters for few years. There will be new respiratory registrars starting later this year and they said it might be a good idea to ask the current trainees to input into the handbook in preparation for the new cohort in August.

Trainers said that there is no fixed programme, but the general structure is that trainees will spend their first 2 years doing GIM at a district general hospital. Trainers meet regularly to discuss trainees as a group and to plan how to satisfy their training needs. They said that the difficulty sometimes is to get trainees to recognise when there is a training opportunity. The Annual Review of Competence Progression (ARCP) decision aid is used to guide learning in order to give trainees a rough guide about the supervised learning events to achieve.

Trainees: Trainees said that they had received induction some time ago as they were in their more senior years of training. They said that they received written materials about the department and that induction was an informal chat with the consultant. One trainee said they did not receive a formal induction because they had already been a junior trainee within the respiratory medicine department. Trainees confirmed that the document is a generic document to provide information about the respiratory medicine unit and is aimed at all trainees who start work in the department. There is no specific StR information. Trainees felt that it would be beneficial if there was targeted StR specific induction information provided.

Deanery North Region

Trainers: The TPD in the North reported that all trainees are provided with an induction on site. There are induction videos on YouTube that the medical team on ward developed as part of a quality improvement project. The TPD or educational supervisor also meets 1:1 with new trainees and gives them specific information about clinics etc, although access to subspecialty clinics continues to be a work in progress. Because of small number of trainees recruited to the North, induction is personalised to each individual trainee and the content of their induction varies dependent on their previous experience.

In the North, trainees spend their first 2 years at Raigmore Hospital for GIM and they are provided an induction for that. This is followed by a GIM and respiratory medicine training year. There are

separate supporting materials for sleep induction and lung etc. It is the role of the ES to provide trainees with the information they require for each training year.

Trainees: Trainees reported a similar experience in the North. Trainees felt that it would be beneficial if there was targeted StR specific induction information provided.

All regions

Trainees in all regions felt that more could be done to provide better information to them about the training programme as a whole and signposting them to relevant training opportunities available to them at different stages of their training. This is particularly true for those working in district general hospitals in Fife and Inverness doing their ST3 in GIM who, while acknowledging that their primary focus for the year is GIM, would appreciate having a wider overview of the programme and signposting about what respiratory medicine competencies could be achieved during their ST3 year and beyond.

3.2 Formal Teaching (R1.12, 1.16, 1.20)

The regional teaching days, known as the National training, are of high quality and trainees report satisfactory attendance rates. National teaching takes place 6 times per year.[1] The Postgraduate Dean for Medicine in the South East region helps to set up the national teaching and will contact consultants throughout Scotland to deliver a variety of sessions. The dates are distributed by the Scottish Thoracic Society. A representative on the specialty training committee (STC) ensures the programme is appropriate. Dates for 2019 are as follows:

- Wednesday 23rd January - Pulmonary Hypertension
- Tuesday 19th March - Respiratory Physiology
- Thursday 20th June - Scottish Thoracic Society Annual Meeting
- Thursday 5th September - Asthma
- Wednesday 23rd October - Genetic and Developmental Respiratory Diseases
- One date outstanding - Non-tuberculous mycobacteria.

[1] Locally delivered training is in line with curriculum requirements and counts towards the remainder 8 day total requirement as specified by the Respiratory Medicine programme curriculum.

All trainees confirmed that there are no problems accessing national teaching. They ensure through rotas that trainees get minimal compulsory attendance.

Regarding local teaching, we heard that all sites have a multi-disciplinary respiratory medicine teaching which takes place on the ward to maximise attendance. Specific details about each region can be found on the following page:

South East

RIE

- respiratory medicine teaching on the ward
- grand ward round for GIM.

WGH

- Tuesday departmental teaching (Dr Leitch)
- grand ward round for GIM
- weekly radiology meetings
- lung cancer and Cystic Fibrosis.

North

Aberdeen Royal Infirmary:

- weekly multi-disciplinary respiratory meeting on Thursdays. (The visit panel was told that this is not specifically mapped to curriculum but it would be a good idea to do so). Teaching is not entirely bleep-free but local teaching opportunities are well attended and on Thursdays the consultant will ensure that trainees are rounded up for teaching.
- Wednesday afternoon there is a lung disease meeting in addition to a journal club.
- grand ward round for GIM.
- quality improvement meetings on Fridays.

Raigmore Hospital:

- StRs rotating through Raigmore Hospital have no formal teaching for respiratory medicine. At the visit is was discussed whether there was the opportunity for Inverness trainees to use VC or to use wifi to access the respiratory teaching opportunities that are available at the Aberdeen Royal Infirmary.

East

Ninewells Hospital:

- Radiology teachings every Tuesday which is well attended.
- Lung cancer meetings.
- Grand round for GIM every Thursday
- Friday respiratory medicine unit teaching which is multi-disciplinary and covers a range of topics. StRs have opportunity to develop their own learning needs identifying topics they want to discuss. More recently they have tried to implement StR specific teaching and the aim is to try and make this routine but so far this aspiration has not been achieved.

3.3 Study Leave (R3.12)

There are no challenges in supporting study leave. Trainees rotating at district general hospitals reported some difficulty in being able to attend respiratory national teaching due to service demands and geographical location. There have been no attempts to use VC facilities so far.

3.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6)

Trainers: All clinical and educational supervisors are recognised as trainers and have time in their job plans. The only exception to this was the TPD in the North who felt that her role was not supported adequately in her job plan.

All supervisors have undergone the formal 'Recognition of Trainers' approval process. The educator role (and any requirements in this regard) are formally reviewed at appraisal. Educational supervisors are encouraged to formally meet with their trainees (at least twice) but this often occurs more frequently. Trainees are advised who their educational supervisors are at induction.

Trainees: All trainees confirmed having met with their ES.

3.5 Adequate Experience (opportunities) (R1.15, 1.19, 5.9)

South East

Trainers: Trainers said that there are ample training opportunities available every day to trainees but often trainers need to signpost these as training opportunities to trainees. Trainers were pleased to report that the South East region now has satellite clinics in pulmonary hypertension and lung transplant, as these were not previously available in the South East. Trainees working in clinics in the South East are supernumerary and have daily one-to-one contact with supervisors. This is a recent development which required a huge effort from trainers to restructure the clinic timetable to enable all clinics to be supervised by a named consultant.

Trainees: Trainees reported that there had good access to training opportunities. At the RIE, gaps in the rota means that they can frequently been seen to be performing duties akin to a core medicine trainee. This was not the case for the WGH which is well supported with consultants. Trainees also reported that at WGH they receive help from physiologist for the reporting of lung function tests through weekly pulmonary physiology training. This was deemed to be an excellent training experience.

North

Trainers: Trainers reported that there are some areas of the curriculum that cannot be achieve in the North region such as lung transplant, tuberculosis and sleep clinics. Trainees must seek a placement experience elsewhere to acquire these competences and are supported to do so. Current trainees have sought out experience such as lung transplant in Newcastle, Pulmonary hypertension in Glasgow and Tuberculosis in London.

In the North, trainers said that the Hospital @ Night rota is well balanced and does not compromise educational opportunities for specialty training. The main issue for the North is consultant time for direct supervision, for example, supervised reporting of lung function is felt to be lacking (although when trainees specifically ask for help in this competence they are supported).

Trainees: Trainees said that their time for specialty training is protected. Because there are only three registrars in the programme, they must complete tasks required of the registrar. The adverse effect of having just a few trainees in programme is that trainees can sometimes find it difficult to find the time to attend clinics because they are needed on the ward. For Inverness, we heard about a known issue that StRs are frequently required for service provision for GIM, but trainees are aware of developments underway to help support their training and GIM is not the focus of this report.

East

The East described a similar experience to the North where trainees must rotate outwith the region to seek out specific competencies, such as a short attachment to cardiothoracic at the RIE. In the last year ward activities have been restructured to allow greater access to direct ward supervision and to increase trainees' uptake of clinic and bronchoscopy slots. Trainees reported access to physiologists and said it would be good to receive specific teaching from them (having heard about this in the South East).

3.6. Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11)

Trainers: All trainers reported that is easy for them to complete trainees' assessments. Formal feedback around the quality and content of educational supervisors' reports is provided to supervisors as a driver to improvement of electronic supervisor's reports. All regions are supported in receiving feedback about their assessments and report by their respective Postgraduate Deans.

Trainees: Trainees did not report any concerns about the quality of their assessments or the ability to achieve them.

3.7. Adequate Experience (multi-professional learning) (R1.17)

All sites described ample opportunities for multi-professional learning, within areas such as severe asthma, interstitial lung disease, lung cancer, complex infection and radiology.

3.8. Adequate Experience (quality improvement) (R1.22)

Trainers and trainees confirmed good participation in quality improvement projects and this is actively encouraged. Interestingly trainees in the East had heard of the Tayside Quality Improvement meeting (TQIP), but had not used this opportunity.

3.9. Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers and trainees all reported good access to clinical supervision with individuals being able to identify the different training grades either by using coloured name badges or this being identified to staff at handover (this was perceived to be adequate given the small number of staff). Trainees said they have never felt that they have had to cope with problems beyond their competence. If a trainee did feel this way, trainees were confident that support would be readily available and said that all consultants are accessible and approachable. However, consultant supervision at respiratory clinics in not universal across all regions with the North region finding it challenging to provide consistent consultant supervision in clinics.

3.10. Feedback to trainees (R1.15, 3.13)

South East

Trainers: Trainers reported that trainees are supernumerary at clinics and therefore are supervised at all times and get good feedback in clinics. There are also two consultant-led daily ward rounds where there is an opportunity to discuss any matters arising.

Trainees: Trainees recognised receiving daily feedback and said feedback was constructive.

North

Trainers: Trainers in the North region said because there is a small number of trainees, they can have regular 1:1 educational supervisor meetings and trainees ‘can easily drop into the office at any time’ if there are any items about training to discuss; this happens regularly.

Trainees: Trainees also recognised receiving daily feedback which is constructive.

East

Trainers: Trainers said that the have recently improved respiratory medicine training so that the wards can operate without StRs, and the multidisciplinary team helps with improved approach. The desired consequence is that trainees now have better access to learning opportunities, such as clinics supervised by consultants enabling more timely feedback to trainees.

Trainees: Trainees in the East also recognised receiving daily constructive feedback from consultants.

3.11. Feedback from trainees (R1.5, 2.3)

South East

Trainers: Trainers said that feedback from trainees is actively sought and that the South East of Scotland programme has two trainee representatives who attend the STC.

Trainees: Trainees confirmed having frequent opportunity to feedback to consultants including at Friday lunchtime meetings, clinics and ward rounds. Trainees also told us they have a trainee representative to whom they can feedback to about any issues about training.

East

Trainers: Trainers said there is a weekly Wednesday meeting which is used by trainees for providing feed back and which has helped improve the interchange of communication about training. Trainers have all been receptive and adaptive to feedback.

Trainees: Trainees in the East confirmed that the TPD has been active in seeking feedback to improve their training. They have also set up registrar meeting for trainees to meet with trainers as a forum for feedback.

North

Trainers: Trainers in the North felt that the open-door policy meant that feedback was a constant between trainer and trainee and trainee to trainer. Trainers felt that the benefit of being a small unit means that educational supervisors have a close working relationship with trainees and they can meet at regular formal (or informal) intervals according to trainees' needs.

Trainees: Trainees felt the same and would not be hesitant to approach their trainers if they had suggestions for their training. The North region does not have a trainee representative.

3.12. Workload/ Rota (1.7, 1.12, 2.19)

South East

Trainers: Trainers reported they work closely with registrars in setting up the rotas and this has worked well.

Trainees: Trainees reported that the rota can be a challenge given rota gaps, including gaps due to vacancies, academic training, less-than-full-time training and out of programme experiences. Additionally, GIM commitment, night shifts and zero days all can add to rota complexity and time away from Respiratory Medicine.

The Rota design with multiple gaps can challenge the aspiration for structured training in blocks. Trainees felt that slots allocation to LTFT and academic trainees should take into account that their availability is not equivalent to a full time trainee and might be better to combine two trainees to cover one slot. Gaps in the more junior rota at the RIE means StRs can find themselves acting down to a core medicine training level.

North and East regions

Trainers in the North reported that the rota is balanced to ensure enough specialty exposure, although acknowledging this can be tough when balanced with GIM, night shifts and zero days. Trainees in the North said their rotas are manageable. Trainers in the East similarly reported that they

have maximised specialty time, and that the main issue is the degree to which the GIM rota encroaches on specialty training because their trainees are on the GIM receiving rota throughout their years of specialty training. Trainers considered that many of the red flags generated by the training surveys would relate to the GIM component. Trainees confirmed that they do not work out of hours for respiratory medicine and that they only cover GIM during out of hours.

3.13. Handover (R1.14)

In summary, no concerns were raised by either trainers or trainees with respect to handover any of the Deanery regions.

3.14. Educational Resources (R1.19)

The following was noted about educational resources:

- Lothian – computers are very slow but this is hospital wide. The wifi was reported to log off every 45 mins.
- Aberdeen Royal Infirmary - was also noted to have slow computers. There is now a registrar's office with 4 PCs. Wifi was reported to be an issue in the hospital. As smart phones are used for ward apps wifi access is required.
- Raigmore Hospital - PCs were considered adequate. It was felt there was inadequate space for dictation because there is only a very small room shared by other trainees.
- Ninewells Hospital - also reported slow computers. They were noted to have a registrar's office.

3.15 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12)

Trainees described supportive educational and clinical supervisors. Support for flexible options such as working less than full time or support for those who had been out of programme for some time was readily available. Less than full time (LTFT) trainees are perceived to have equal (proportionate) access to training opportunities. We heard in all regions examples where reasonable adjustments were in place for those requiring it. One trainee in the South East particularly wanted to highlight the support they had received as exemplary. For trainees returning to work after a career break, the South East region demonstrated good practice by catering for a supernumerary period with no on-call commitments for the first month. The East also had examples of adjustments made following a career

break. However, trainees in the East region did not benefit from a phased return to work following a prolonged career break, reporting being on-call within 2 weeks of returning to work.

3.16 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1)

This item was not discussed with either trainers or trainees.

3.17 Raising concerns (R1.1, 2.7)

South East

Trainers: Trainers said that trainees are encouraged to raise concerns both informally and formally and are encouraged to use Datix. Themes from Datix are unpicked and are discussed at morbidity and mortality meetings (M+M) which trainees are invited to attend. Learning from Datix may also be incorporated into training days as the TPD is alerted to any Datix raised by a trainee.

Trainees: All trainees were aware of Datix, were happy to report incidents via Datix and knew how the feedback mechanism from reporting incidents via Datix worked. They mentioned the monthly M&M meetings and the role of the Chief Registrar in collating Datix themes. Trainees felt that Friday unit meetings were also an opportunity to raise concerns as well. At the WGH, Datix incidents were noted to be received by the clinical director who would feedback themes for discussion.

North and East regions

Trainers and trainees in the North and East programmes also confirmed using Datix for reporting incidents. Trainers said it was important to have an environment where trainees feel they can raise concerns safely. When trainees in these regions were asked, all confirmed being comfortable about their ability to raise concerns, none had any issues with escalating concerns and everyone was noted to be open and supportive.

Reporting systems was noted to have received a red flag in the NTS survey for the East region. When trainees were asked why this might be the case they were unable to explain the red flag for

respiratory medicine, and suggested that this perhaps relates to trainees' experiences in the acute medicine unit/GIM.

3.18 Patient safety (R1.2)

All Trainers: Trainers reported site huddles, ward huddles and handover as opportunities to discuss any issues pertaining to patient safety. There were no specific issues related to patient safety raised by any of the trainers.

All Trainees: Trainees also had no concerns with respect to patient safety in any of the sites where the respiratory medicine training programme is delivered.

3.19 Adverse incidents (R1.3)

See section 3.17.

3.20 Duty of candour (R1.4)

Trainees: All cohorts of trainees said there is an open culture where they work, and they would feel supported if they were involved in an incident where something went wrong.

3.21 Culture & undermining (R3.3)

Trainers and trainers said that there is a positive team culture in all sites within the respiratory medicine programme. All trainers try to foster an open culture for people to raise concerns, and trainees are encouraged to approach their educational supervisors and TPDs regarding any perceived undermining remarks. All three regions were able to describe an instance where this was the case and this was deemed to be handled appropriately by both trainers and trainees.

3.22 Other

All group of doctors were asked to rate their overall experience of their placement and the average scores are presented below:

ST3+ Grampian Range = 6 – 9, Average = 7.5 out of 10.
ST3+ Tayside Range = 7 – 10, Average = 8 out of 10.
ST3+ Lothian: Range = 7 – 10, Average = 8.4 out of 10.

4. Summary

Overall, this was a positive visit. It was clear that the programme delivery across each region was unique adapting to number of trainees and local opportunities. However, in all regions the respiratory medicine programme was able to deliver the curriculum by offering trainees placements at other locations to meet their specific learning needs. All trainees reported receiving regular feedback from their trainers and were comfortable to raise any concerns about training both informally and formally. Each region has its own unique challenges, however, it is clear that trainers were dedicated to working with trainees to provide satisfactory training experiences and that trainees felt they were working in an environment which was supportive and nurturing.

Positive aspects of the visit:

- Trainers across all three regions are approachable and committed to providing high quality training.
- Induction in the South East is supported by a comprehensive handbook that is regularly updated with trainees' input.
- Aberdeen Royal Infirmary in the North Region has a series of YouTube videos that are available for trainees of all levels.
- National training days are of high quality and trainees report satisfactory attendance rates.
- Trainers across all three regions support their trainees to achieve curricular competences, including signposting training opportunities that exist out with their regions such as lung transplant in Newcastle, Pulmonary hypertension in Glasgow and Tuberculosis in London.

- Multi-professional learning opportunities are widely available, for example the physiologists in Western General Hospital (South East) are actively involved in teaching StRs including formal reporting of pulmonary function tests.
- Good support for trainees returning to work following a career break, particularly in the South East region.
- Arrangements for clinical supervision by consultants in clinics are satisfactory in the East and South East.

Less positive aspects of the visit:

- Time for educational supervision in consultant job plan was reported to be lacking in Aberdeen Royal Infirmary.
- Across all regions ST3 induction was felt to be ad hoc and trainees would appreciate a specific induction for respiratory medicine as a programme at ST3 level.
- Rota gaps due to a combination of unfilled posts, LTFT training and out of programme experiences were perceived to challenge the balance between training and service delivery in all regions.
- While regional training was mapped to the curriculum respiratory departmental teaching felt less structured and trainees reported lack of clarity around its relevance to the curriculum.
- Computers across all regions were reported to be slow resulting in unnecessary delays and frustration to all members of the team.
- Trainees in the East region did not benefit from a phased return to work following a prolonged career break, reporting being on-call within 2 weeks of returning to work.

Is a revisit required?	**Yes**	**No**	**Highly Likely**	**Highly unlikely**

5. Areas of Good Practice

All Programmes

Ref	Item	Action
5.1	Comprehensive national teaching programme which is mapped to the curriculum and is rated by the trainees as excellent.	None

5.2	Trainees are provided with a wide range of opportunities to cover the breadth of their curriculum across the different sites and achieve their competences flexibly by the end of the 5 years.	None
5.3	Multi-professional learning opportunities are widely available.	None
5.4	Trainers across all three regions are approachable and committed to providing high quality training.	None

South East Programme

Ref	Item	Action
5.5	Restructuring of respiratory clinic schedule to ensure trainees are always supervised by consultants at clinics.	None
5.6	Physiologists in Western General Hospital (South East) are actively involved in teaching StRs including formal reporting of pulmonary function tests.	None
5.7	Good support for trainees returning to work following a career break.	None
5.8	Colour coded badges to identify trainee grades.	None

East Programme

Ref	Item	Action
5.9	Restructuring of training and ward activity to allow greater access to direct ward supervision and to increase trainees' uptake of supervised clinics, subspecialty blocks and OOP activity throughout training.	None
5.10	Colour coded badges to identify trainee grades.	None

North Programme

Ref	Item	Action
5.11	Aberdeen Royal Infirmary in the North Region has a series of YouTube videos that are available for trainees of all levels.	None

6. Areas for Improvement

All Programmes

6.1	The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.	DMEs to investigate.

Specific to East Programme

Ref	Item	Action
6.2	Support for trainees returning to practice after a career break was inconsistent and trainees in the East region did not benefit from a phased return to work following a prolonged career break, reporting being on-call within 2 weeks of returning to work.	The TPD should ensure that support for trainees is consistent and meets guidelines, particularly a phased return to on call commitments.

7. Requirements - Issues to be Addressed

All regions

7.1	ST3 Trainees must be provided with a programme induction led by the Training Programme Director.	TPDs must provide a programme induction that provides an overview to respiratory medicine training, including what respiratory medicine components can be achieved during ST3.
7.2	Alternatives to doctors in training must be explored and employed to address the staffing in the junior rota that is impacting on the training of ST trainees who are being used to provide this cover.	TPDs must explore this with their relevant DME.
7.3	Departments must develop and sustain a local teaching programme relevant to respiratory curriculum requirements of the ST3+ trainees including a system for protecting time for attendance.	TPDs must evaluate delivery of local teaching programme with specialty specific teaching mapped to curriculum.

Specific to North Programme

Ref	Item	Action
7.4	All clinical and educational supervisors recognised as trainers must have time in their job plans.	TPD must explore with DME of NHS Grampian.
7.5	Specialty trainees must not undertake outpatient clinics without access to on-site, in-clinic consultant supervision.	TPD in the North must explore with their relevant DMEs.