Date of meeting	24th February 2025	**Reason for meeting**	Moray Maternity Services project
Type of meeting	Educational Engagement Meeting	**Hospital**	Dr Gray's Hospital, Elgin
Specialty(s)	Obstetrics and Gynaecology, Paediatrics - Neonatology, Anaesthetics	**Board**	NHS Grampian

Meeting panel	
Professor Alan Denison	Meeting Chair - Postgraduate Dean
Dr Marion Slater	Deputy Postgraduate Dean
Dr Alastair Campbell	Associate Postgraduate Dean for Quality/Consultant Obstetrician
Dr Chris Lilley	Associate Postgraduate Dean – Obstetrics and Gynaecology and Paediatrics/Consultant Neonatologist
Dr Duncan Henderson	Associate Postgraduate Dean – Foundation/Consultant Anaesthetist
Dr Chris Mair	Assistant Director for General Practice
Mr David Soden	Lay Representative
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Ms Patriche McGuire	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Obstetrics and Gynaecology, Paediatrics and Diagnostics
Lead Dean/Director	Professor Alan Denison
Deputy Lead Dean/Director	Dr Marion Slater
Quality Lead(s)	Dr Alastair Campbell, Mr Brian Stewart
Quality Improvement Manager(s)	Ms Gillian Carter, Ms Helen Pratt
Unit/Site Information	
Non-medical staff in attendance	1
Trainers in attendance	7

Feedback session: Managers in attendance	Clinical Leads and Programme Leads	√	DME	√	ADME		Medical Director	√	Other	

Date report approved by Meeting Lead	1st April 2025

1. Principal issues arising from pre-meeting review:

NES has been involved in discussions relating to the resumption of full obstetric services in Dr Gray's Hospital, Elgin, following the announcement of the 'Model 6' decision in 2023.

A number of issues had been identified by the Deanery which they wished to discuss with the team in NHS Grampian and at Dr Gray's Hospital. These included:

1. The Target Operating Models (TOMs), the reliance therein on Resident Doctors in Training (RDIT) and the suitability and deliverability of this approach to supply the desired future medical workforce.
2. The number and funding of anticipated doctors in training grade and non-training grade posts and the skills they are required to have. The NHS Grampian business case and revisions have not included funding for RDITs or for local educational infrastructure (e.g. board-appointed educators/supervisors).
3. Observations from regional Directors of Medical Education (DMEs) and Training Programme Directors (TPDs) about the suitability of the Dr Gray's site for postgraduate Higher Specialty Training for the RDITs described by the TOMs, including the provision of educational and supervision staffing.
4. Neonatal service planning and the extent of anticipated curricular opportunities that will be available.
5. Anaesthetic medical staff training grade cover plans, including curriculum and supervision arrangements.

The Deanery team wished to meet with relevant individuals associated with this project to discuss their plans for the resumption of full obstetric services at Dr Gray's Hospital and to explore these issues in order that NES can optimise its support to the board. The team were also interested in examples of good practice for sharing more widely.

A summary of the discussions has been compiled under the headings in section 2 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 themes listed within the standards.

The panel would like to thank Dr Morag Turnbull, Consultant Paediatrician and Programme Lead for the Moray Maternity Services project, for the informative presentation given at the start of the meeting outlining the progress already made on the project and the areas currently under discussion.

Currently the site has a mixture of FYs and GPSTs working in Women's Health posts which cover both Obstetrics and Gynaecology and Paediatrics. There are also some FYs working within Anaesthetics. The new model would see the introduction of additional RDITs to the site to allow full obstetric services to be provided.

The project team noted that they are currently working on a new version of the project model which is currently being referred to as 'Model X'. They anticipate this being completed within the next 2 months and will share this with the Deanery when finalised.

2.1 Theme 1: Learning Environment and Culture

The team felt that Dr Gray's Hospital could be a supportive environment for RDITs at appropriate training stages in Obstetrics & Gynaecology and Paediatrics. The Obstetrics and Gynaecology department described a culture of recognising that training and service go hand-in-hand with opportunities to be involved in clinics and theatre lists. Similarly, the Paediatrics department noted many opportunities to attend clinics and a culture of RDITs being encouraged to gain supported practical experience rather than only shadowing consultants. Currently there are 3 educational supervisors in Obstetrics and Gynaecology and 5 in Paediatrics.

Access to teaching is currently supported by consultants holding bleeps during teaching and not running clinics to allow attendance at morbidity and mortality (M&M) meetings. Handover takes place for the whole team in the morning and then bleeps are handed over in the evening. The departments would anticipate that these processes would continue in the same way following implementation of the new maternity model.

Consultants in Obstetrics and Gynaecology reported that they avoid attrition of skills by spending at least 1 day every 6 months doing a list of elective Caesarean sections in Aberdeen and would plan to continue this as well as doing locum work to assure their competence to perform procedures and

supervise RDITs. Dr Louise Millar was described as making a positive contribution to training for supervisors on the Dr Gray's site and trainers felt well supported.

The department described wellbeing initiatives including RDIT meetings and forums, supportive small departments and pizza meetings.

2.2 Theme 2: Educational Governance and Leadership

The team reported that they have an educational governance structure for the Board but have not yet confirmed how the new elements of the maternity project will be integrated into this. Governance meetings take place within the site every 4 months at which any curriculum changes or site changes which may impact training would be discussed. It was felt that the Obstetrics and Gynaecology curriculum was well-suited to integrating with service needs.

The team confirmed that the quality of medical education is monitored through the National Training Survey (NTS) and Scottish Training Survey (STS) as well as through monthly RDIT forum meetings where RDITs can give feedback about their training. These meetings are run by the Associate Director of Medical Education (ADME). There is also a departmental RDIT meeting every 6 months which is recorded and notes stored confidentially. Survey results are reviewed by the DME and discussed and addressed within the site as required. Feedback about any issue arising is given to the responsible officers.

Since the number of potential supervisors has increased recently there were no concerns about fitting sufficient time into job plans for supervision as this has been managed well previously with lower capacity. In terms of RDIT requirement for the new model, the team felt that the best way to establish anticipated RDIT numbers was to design the service and then work out the number of doctors needed. This would then be aligned with training opportunities, as colleagues in non-training grade posts or other disciplines will also be required and RDIT should therefore be matched to training availability and not service need. The site planned to have a minimum of 8 RDITs on the junior tier rota as well as specialty doctors. It was anticipated that shifts would be either fully in Obstetrics and Gynaecology or fully in Paediatrics but this had not yet been finalised. There were no draft rotas at this stage. Previous interest in clinical fellow posts in General Surgery and RDITs' enthusiasm to

come from Aberdeen for Gynaecology theatre lists has given the team confidence in the ability to fill the required additional posts.

2.3 Theme 3: Supporting learners

The team reported that they offer a half day site induction to all new RDITs on their first day and then they move to their department for a departmental induction. RDITs starting posts in Women's Health have induction to both Obstetrics and Gynaecology and Paediatrics and induction is repeated for any doctors who cannot attend on the first day. Neonatal and paediatric resuscitation are covered as part of induction. It is not feasible to offer a formal resuscitation course to all RDITs as some are only in the department for 4 months, however someone qualified in neonatal life support will always be present in the department and there will be an absolute requirement for Advanced Neonatal Nurse Practitioners (ANNPs) to be qualified in resuscitation. ANNPs will maintain their skills by completing shifts in Aberdeen or Inverness. The team described their approach to RDITs entering the department as 'supervised independence' where they would offer bespoke opportunities to RDITs, but would always have consultant support available. Consultants expect to be called first to respond to emergencies.

In terms of wellbeing, the team reported that a 'soft start' is offered to all International Medical Graduates (IMGs) to give them a longer induction period. The department tries to accommodate RDITs at their own level of comfort when they start and find that they usually settle in well. During working hours RDITs were described as congregating in the area between the Obstetrics and Gynaecology and Paediatrics wards rather than in the doctors' mess which provides them with peer support. They can also give feedback at the RDIT meetings and forums. The team thought that RDITs supported each other well across different grades on the Hospital at Night rota which was recently introduced and these relationships promoted wellbeing.

2.4 Theme 4: Supporting educators – Not covered

2.5 Theme 5: Developing and implementing curricula and assessments

The team noted that they anticipated around 800 women in the area giving birth every year of which 20% would be midwife-led, 20% planned Caesarean section, 40% on the labour ward and 20% would

travel to Aberdeen due to being high-risk. Conversations are also ongoing regarding widening the geography covered by the hospital so these figures may change in future. The Deanery panel expressed willingness to support the site team with curriculum mapping as this had not yet been completed. It was also suggested that the Deanery could put the department in touch with other departments who were known to have gone through a similar process such as units in Morecambe Bay and Orkney.

In general, the team felt that there was enough activity at the site that experience would not be diluted by the proposed changes. There was also an opportunity for STs to travel to different hospitals if needed to gain competencies that were more challenging to obtain at Dr Gray's Hospital. The team did not foresee any issues with obtaining workplace-based assessments as RDITs are told how to send tickets at induction and it was felt that this process works well. RDITs are encouraged to complete quality improvement projects and often have more time to do this at Dr Gray's Hospital compared to busier sites.

For doctors needing additional help, the team reported that they would continue to offer this on an ad hoc basis and did not feel that rising numbers would make this difficult as RDIT numbers are overall still quite small.

Obstetrics and Gynaecology: The maternity model requires the introduction of specialty RDITs in Obstetrics and Gynaecology to the site. The team were confident that they could offer all aspects of the stage 2 curriculum, although as the site had a lower volume of patients some aspects of the ST5-7 curriculum could be more different to achieve compared to the ST1-4 curriculum. It was anticipated that STs may need to travel to Aberdeen or Inverness to obtain certain competencies although it would be possible to deliver a wider range of Gynaecology competencies in Elgin compared to Obstetrics. It was noted that Dr Gray's Hospital already offers multi-disciplinary simulation training, for example simulated Caesarean-sections, and would continue this under the new model.

In terms of access to teaching, the team reported that there was a Teams channel for Obstetrics and Gynaecology teaching, although it was recognised that this could be less relevant for FY and GPST doctors. FYs and GPSTs were reported to be able to attend all of their regional teaching when working in the department.

It was noted that the TPD for Obstetrics and Gynaecology had some concerns regarding moving RDITs to this site and these had not yet been fully resolved. It was not yet clear from where the required RDITs would come, however suggestions included that they come from other sites in the North region for shorter blocks or from outside the North region. Travel distance has previously been raised as an issue for those wishing to come from Inverness to gain specific competencies.

Paediatrics – Neonatology: The team reported that neonatal skills are already covered during induction and many of the skills already taught in the Paediatrics department would be relevant to the introduction of a neonatal unit. The team were confident that the core aspects of the Paediatrics curriculum could be met in this post. However, it was not anticipated that specialty RDITs in Paediatrics would be required as part of the new model and it was expected that ANNPs would be able to fill the tier 2 rota. Nonetheless the site recognised that good opportunities could be available for middle or early level STs, for example in clinics or in Community Child Health, if the opportunity arose. The junior rota for the new maternity model is planned to be filled by FY and GPST doctors. It was not felt that it would be an ideal location for gaining neonatal competencies as the neonatal unit would be a small unit with only 4-6 cots. In a neonatal emergency it would be expected that ANNPs would be trained in initial stabilisation and a consultant would be bleeped at home so there would be no expectation for FY or GPST doctors to respond to neonatal emergencies. Neonatal teaching currently takes place roughly every 6 months with consultants or ANNPs coming from Aberdeen to provide teaching. Staff at Dr Gray's can request specific topics to be covered if desired.

Anaesthetics: Similarly, the team did not anticipate that RDITs in Anaesthetics would be required to support the new model. The team planned to have 2 specialty doctors supporting Anaesthetics of which one would be on-site and one would be off-site. All on-calls would be done by consultants. Any RDITs who came to work at the site in the short term would be required to be at least of stage 2 level. The site recently supported a resident doctor from Inverness to come for a week of experience at Dr Gray's Hospital.

Foundation: The team felt that the training opportunities for FYs were currently robust, but the maximum number of FYs they could support would be 10 as more would dilute the training opportunities available. This number may rise in future as the work in Obstetrics and Gynaecology and Paediatrics develops.

General Practice: A discussion took place regarding whether Obstetrics and Gynaecology and Paediatrics might be split into 2 separate posts for GPSTs rather than current mixed post, however it was noted that historically this was not popular as cross-cover was required which made the posts when separated very similar. Reassurance was given that GPSTs would not be expected to respond to neonatal emergencies due to the escalation plans described above. It was noted that 6 months' notice would be required to send additional GPSTs to the department.

3. Summary

Positives

- The panel found a group of very engaged and enthusiastic consultants and managers who were taking a person-centred approach to the project and were focused upon training needs and opportunities rather than purely service needs.
- Those involved in the project were open to looking at new ideas and alternatives to the original Model 6 plans with a Model X plan now being developed.
- Wellbeing was a priority across the departments with a strong commitment to regular meetings with RDITs and to fostering good relationships within the small departments.
- The work around simulation was innovative and beneficial.
- Elective Caesarean sections are planned to commence imminently.
- There are good potentials for training in Community Child Health and Gynaecology surgery.
- Recruitment and training of perinatal nursing workforce and other staff is progressing.

Areas for further consideration

- The panel noted that plans for Model X are not yet available and that this would be needed to fully identify how NES could support.
- The panel noted the anticipated volume of full obstetric care/intrapartum cases from 2027 at Dr Gray's (e.g. approximately 1 to 2 Caesarean sections per week) and the need for planning for skills maintenance amongst all staff to support education and training.
- Funding had not yet been confirmed for the project beyond the introduction of elective Caesarean sections.
- NES noted observations regarding the current accommodation provision for RDITs.

- While there is very committed operational clinical leadership of component parts of the maternity service, overarching senior clinical oversight for the overall Moray Maternity Collaborative could be further developed.

Areas for further action

- NES would be pleased to comment on the Model X plan once this has reached a suitable stage of development. It is suggested that this includes details on timescales, transition/steady state composition of rotas, detailed levels of service staffing including intrapartum and perinatal care and an embedded education strategy.
- The panel heard that obstetric anaesthetic considerations related to planning for 24/7 full intrapartum care were currently 'parked' and would encourage that these conversations are progressed.
- The panel suggests that curriculum mapping for specialties where there may be opportunities for RDITs is undertaken by the Board and would be pleased to offer its support with this.
- NES would be pleased to discuss further with the maternity collaborative team what regular interactions/communications would be helpful.

The meeting concluded with an agreement to plan a further meeting within the next few weeks between the Meeting Lead/Deputy Lead from the Scotland Deanery and key individuals from the project team. The Deanery will continue to provide support to the maternity project team and trainers in the relevant departments throughout the introduction of the new model.