Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	5th March 2025	**Level(s)**	FY, GPST, ST
Type of visit	Triggered	**Hospital**	Aberdeen Royal Infirmary/Aberdeen Maternity Hospital
Specialty(s)	Obstetrics and Gynaecology	**Board**	NHS Grampian

Visit panel	
Dr Alastair Campbell	Visit Lead – Associate Postgraduate Dean for Quality
Dr Caithlin Neill	Training Programme Director – Obstetrics and Gynaecology
Dr Karen Rose	Foundation Programme Director
Dr Juli Dalgleish	Training Programme Director – General Practice
Dr Sarah Jarvis	Resident Doctor in Training (RDIT) Representative
Mr Brian Harrison	Lay Representative
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Ms Lauren Hart	Quality Improvement Administrator

Specialty Group Information			
Specialty Group	Obstetrics and Gynaecology, Paediatrics, 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	6		
Trainers in attendance	9		
RDITs in attendance	FY: 5	GPST: 1	ST: 12

Feedback session: Managers in attendance	Chief Executive		DME	√	ADME		Medical Director	
	Other: Induction Lead, Lead Nurse for Women's Services, Lead Midwife, Director of Midwifery, Unit Operational Manager, Service Manager, Medical Education Quality Manager, Clinical Lead							√

Date report approved by Lead Visitor	27th March 2025

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data at the 2024 Deanery transitional Quality Review Panel (QRP), Aberdeen Royal Infirmary/Aberdeen Maternity Hospital was identified for a Deanery visit for Resident Doctors in Training (RDITs) in Obstetrics and Gynaecology.

The panel had concerns relating to culture having noted a red flag for supportive environment on the GPST National Training Survey (NTS), a pink flag for team culture on the All Trainee Scottish Training Survey (STS) and red flags for discrimination and equality and inclusivity on the GPST STS.

The proposal to visit was supported by the Director of Medical Education (DME) and the GP Assistant Director. The panel wished to discuss issues surrounding culture with the trainers and RDITs, in addition to any other areas which may emerge through the pre-visit questionnaire and upcoming STS surveys. They were also interested in any 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 requirements listed within the standards.

The panel would like to thank Dr Mary Cairns, Clinical Director, for her clear and informative presentation describing the recent challenges identified within the department and steps taken to address these.

2.1 Induction (R1.13):

Trainers: Trainers reported that they perceived induction to be well organised and always knew plans well in advance. They felt that expectations of what RDITs could remember from a single day of induction could be too high and so had started a Teams channel containing induction materials to which RDITs could refer afterwards.

RDITs: RDITs reported that they all received an induction to both the hospital and department and found this helpful and thorough. They were aware of the recent introduction of a Teams channel for induction materials.

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

Trainers: Trainers reported that local teaching is led by consultants and theatre lists and clinics are cancelled to allow attendance. All RDITs are therefore able to attend except those on-call. In terms of regional teaching, dates for FY teaching are sent by the local administrator and they try to enable as many RDITs as possible to attend. STs also have teaching built into the rota. For other teaching sessions RDITs are encouraged to work as a single team and hold each other's bleeps to enable others to attend.

FY/GPST RDITs: RDITs reported that they received 1 hour of local teaching per week on a Wednesday lunchtime which they found good, but sometimes could not attend due to clinical workload. They felt it would be an improvement if this teaching was protected and bleep free. RDITs in this cohort had initially struggled to attend regional teaching at the start of the block, but now could almost always attend. They did not have any concerns about meeting their teaching requirements within the current block.

ST1-ST4 RDITs: RDITs described peer teaching for ST2s and below taking place every week for 1 hour and reported they could attend usually every second week. RDITs reported that the department Continuing Medical Education (CME) session takes place once per month however this is only protected for ST3+ RDITs. RDITs in this cohort reported that they can generally attend about 3 times per year. RDITs could also attend multi-disciplinary team meetings and risk management meetings, although ST1s found these harder to attend. In terms of regional teaching, RDITs confirmed that they got time off to attend this.

ST5-ST7 RDITs: RDITs reported that they could attend all local and regional teaching as long as they were not on-call for the labour ward or on night shift. They confirmed that clinics were cancelled to allow specialty RDITs to attend teaching.

2.3 Study Leave (R3.12) – Not covered

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

Trainers: Trainers reported that they have SPA time of 1 hour per RDIT in their job plan. They find the Training Programme Director (TPD), Dr Gail Littlewood, to be very supportive and she is happy to meet jointly with RDITs as needed. Trainers felt they received the information they needed regarding RDITs with known concerns as new RDITs are generally coming from Inverness and there is good dialogue between supervisors. Trainers noted that the TPD meets with all RDITs following their Annual Review of Competence Progression (ARCP) to check on their progress and areas of need.

FY/GPST RDITs: RDITs advised that they all met their supervisor at the start of the block and found them to be accessible.

ST1-ST4 RDITs: RDITs reported that they meet their supervisor almost every month and have no issues accessing them.

ST5-ST7 RDITs: RDITs described having a formal meeting with their supervisor once per month but also working closely with them every day. They had no issues accessing their supervisor.

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

Trainers: Trainers advised that there are clear escalation routes for RDITs with queries either being directed to STs on the ward or to the on-call consultant. Sub-specialty RDITs contact their sub-specialist supervisors with any queries. Trainers described promoting a culture where RDITs are encouraged to discuss areas of concern with a consultant before they leave the ward. They felt that as a consultant group they were approachable. They recognised the need to continually encourage trainees to seek support and to have an open manner to help trainees feel comfortable coming to them.

RDITs: RDITs knew who to contact for supervision both during the day and overnight and felt the process of seeking supervision was clear. RDITs reported that they never had to work beyond their

competence and more junior RDITs found STs in Obstetrics particularly helpful when they needed support. Consultants were described as very accessible.

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

Trainers: Trainers noted the extensive opportunities for theatre experience in the department and by attending lists at Stracathro Hospital, Brechin. They noted that it could be more difficult to gain experience of complex surgeries unless RDITs were completing specific Special Interest Training Modules (SITMs) and on labour ward certain procedures were harder to gain experience of such as Kiwi ventouse birth and manual removal of placentas. RDITs are encouraged to write their names on a board for procedures they require so they can be prioritised for these when they arise. Trainers felt that most of the work done within the departmental was educational as working in the specialty requires both maintenance of basic skills as well as acquisition of new skills. They noted that administrative time was built into all rotas and RDITs on night shift were encouraged to complete discharge letters during the night to avoid these all needing to be done by the day team. The TPD was praised for being active in ensuring that RDITs are able to gain all of their competencies.

FY/GPST RDITs: RDITs reported that senior colleagues were supportive and willing to teach and felt they could meet their required competencies in this department. GPSTs were described as having good access to clinics and, whilst FYs had lower access, they recognised that this was less important for them and were happy with the theatre experience they were able to have. RDITs felt they had ample experience of managing acutely unwell patients when in triage where they were always supported by a senior colleague. RDITs found working in triage or the Gynaecology ward to be educational, but found tasks on the labour ward to be less educational.

ST1-ST4 RDITs: RDITs described frequent opportunities to attend clinics from ST3 level although fewer opportunities in ST1 and ST2. RDITs felt that they generally had good opportunities to complete their competencies. The only difficulties they encountered were with procedures that were less common such as Kiwi ventouse birth. RDITs felt they had good experience of managing acutely unwell patients in Obstetrics, although did not see many unwell patients in Gynaecology. Overall RDITs felt the post was well balanced educationally and they had ample learning opportunities.

ST5-ST7 RDITs: This cohort agreed that most competencies were straight-forward to obtain, but there were fewer opportunities to practice rare procedures. Sub-specialty RDITs have to go out of the region to attain all of their competencies. RDITs felt they had good opportunities to manage acutely unwell patients and felt that non-educational work had reduced as they had gone through their training.

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

Trainers: Trainers noted that RDITs are encouraged to raise tickets for workplace-based assessments in a timely manner, however they were aware of reports of tickets not being completed.

FY/GPST RDITs: RDITs found it quite easy to complete their workplace-based assessments with STs described as particularly helpful with this. They described it being slightly more difficult to have assessments completed when the department was busy. RDITs felt their assessments were fair and consistent.

ST1-ST4 RDITs: RDITs found it easy to complete their workplace-based assessments in this post. They reported that certain senior colleagues were slow to complete assessments and so they avoiding sending tickets to these individuals. They felt their assessments were fair and consistent.

ST5-ST7 trainees: Trainees reported that they were able to get all the workplace-based assessments that they needed although, despite some recent improvement, there are still some consultants who don't complete tickets. Nonetheless, RDITs noted that if they raise non-completion of tickets as a concern this is escalated appropriately. They felt their assessments were fair and consistent.

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

Trainers: Trainers reported that RDITs in Obstetrics are encouraged to attended Practical Obstetrics Multi-Professional Training (PROMPT) courses while in Gynaecology there is regular multi-disciplinary teaching.

FY/GPST RDITs: RDITs described a multi-disciplinary team panel taking place during clinic days where they were able to learn from other healthcare professionals. They noted that they do not have a lot of experience of working with pharmacists.

ST1-ST4 RDITs: RDITs reported that they do not routinely have formal learning alongside midwives, however they attend PROMPT courses every 2 years and learn from midwives while on the wards. In ST1 RDITs spend time shadowing a charge midwife to increase awareness of their role. Like FYs/GPSTs, this cohort noted that they do not have much interaction with pharmacists.

ST5-ST7 RDITs: RDITs confirmed that they spend time becoming familiar with the role of charge midwives and other member of the multi-disciplinary team. Towards the end of their training they can work with other healthcare professionals as part of SITMs.

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

Trainers: Trainers reported that they were supportive of RDITs being involved in quality improvement work including audits, risk management and updating processes. They noted that they regularly supervise projects in these areas. Audit presentations are given regularly at CME days. It was also noted that RDITs wishing to apply for specialty training in Obstetrics and Gynaecology require experience of quality improvement work and so often request to come and do a project within the unit which is supported.

RDITs: RDITs reported that they had opportunities to complete quality improvement projects in this department and were encouraged to do so every year. It was also noted that there were excellent opportunities for academic RDITs within the department including an early career academic pathway, support in applying for the Scottish Clinical Research Excellence Development Scheme (SCREDS) and support for higher degrees.

2.10 Feedback to RDITs (R1.15, 3.13)

Trainers: Trainers reported that RDITs asked for feedback regularly as they valued immediate feedback on decisions and found their senior colleagues approachable. They described having a good dialogue with RDITs whereby negative feedback was provided as part of a discussion rather

than a criticism. General issues are fed back more widely and the departmental newsletter includes positive feedback. All incident reviews look for areas of positive feedback as well as analysing what could have been done better.

FY/GPST RDITs: RDITs reported that they always receive feedback when they ask for it, but not always spontaneously. The feedback they receive they find helpful and constructive. RDITs felt that their senior colleagues gave them autonomy to make plans and then provided feedback to help them fine-tune those plans.

ST1-ST4 RDITs: RDITs reported that they receive adequate feedback on their clinical decisions.

ST5-ST7 RDITs: RDITs advised that they work often with indirect supervision at this stage of their training, but receive feedback and help with queries when they request this. They felt the feedback they received was constructive.

2.11 Feedback from RDIT (R1.5, 2.3)

Trainers: Trainers reported that there is a RDIT forum for STs and they bring feedback from this meeting to trainers. They felt RDITs were comfortable approaching senior colleagues and that RDIT representatives were valuable.

FY/GPST RDITs: RDITs thought there was a RDIT representative who was an ST2, but did not know to where this representative reported.

ST1-ST4 RDITs: RDITs reported that there are regular meetings with consultants where RDIT representatives present feedback.

ST5-ST7 RDITs: RDITs reported that they could give feedback through the RDIT committee, including anonymous feedback, and also feel comfortable giving feedback to the TPD.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that measures have been taken to improve culture in the department such as introducing a Workplace Behaviour Champion and Active Bystander training. The management team were described as very supportive in addition to trainers being approachable. An incident was noted whereby an FY1 gave negative feedback about interactions with midwives and this was addressed and resolved.

FY/GPST RDITs: RDITs reported that their senior colleagues had been very supportive so far. A single incident of a negative interaction with a midwife was reported, but it was noted that this had been escalated locally and the RDIT had received feedback about the outcome.

ST1-ST4 RDITs: RDITs felt their senior colleagues were very supportive and had no concerns relating to bullying or under-mining. If they did experience or witness any concerns they felt confident that they knew how to raise these.

ST5-ST7 RDITs: RDITs agreed that their senior colleagues were very supportive and they had no concerns relating to bullying or under-mining. They noted that the department had a Workplace Behaviour Champion and were encouraged to approach her with any issues. They were aware of colleagues speaking to her about concerns and felt these had been managed appropriately.

Following on from the visit, feedback was received by the Visit Lead in a confidential manner with some concerns in relation to the workplace culture and behaviours. This is being further explored through the DME team and being monitored through Quality Management processes.

2.13 Workload/Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that the tier 1 rota was currently fully staffed and the registrar rota had recently moved from 14 to 16 people which provides a lot of support for the tier 1 doctors. FYs, GPSTs and ST1s are on the tier 1 rota with ST2s on a personalised rota to prepare them to move up to the registrar rota. It was noted that from April there will be 1.5 fewer RDITs on the junior tier due to a GPST gap and a RDIT doing Community Sexual and Reproductive Health which will make it more difficult to support things like Taster weeks.

RDITs: RDITs noted that there were currently no gaps on their rota as 3 Locum Appointments for Training (LATs) had joined the senior rota. They confirmed that rotas accommodated specific needs and gave an example of a RDIT going to work at a peripheral site where they would be the only RDIT to increase their theatre experience. STs felt that theatre lists could be improved by scheduling RDITs of different grades on together as their training needs are likely to be different, rather than scheduling RDITs of the same grade whose training needs may be the same. RDITs had no concerns about the rota in relation to wellbeing.

2.14 Handover (R1.14)

Trainers: Trainers noted that the handover process was changed around 2 years ago to better support the split site model so it now takes place solely in the Maternity Hospital at 8am and 8pm. Both are done face-to-face. If time allows, trainers use handover to ask RDITs about their goals for the day.

RDITs: RDITs reported that there were 2 handovers per day at 8am and 8pm. Some RDITs felt there was a structure for handover on the labour ward, but reported that handover on the Gynaecology ward was ad hoc. The Obstetric consultant was described as attending handover, but RDITs reported that the Gynaecology consultant did not start until after the morning handover and would have left prior to the evening handover. Most RDITs did not feel handover was a learning opportunity.

2.15 Educational Resources (R1.19)

Trainers: Not covered.

RDITs: RDITs reported that there are training rooms available in the hospital and IT facilities were adequate, although they had struggled to find a pelvic model when needed. STs noted that some of their cohort had their own offices, however run-through RDITs had to share offices and felt access to computers could be better.

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

Trainers: Not covered.

RDITs: RDITs were confident support would be offered for RDITs who were struggling and some had experience of this being offered via consultants and the management team. RDITs were aware of accommodations being made for RDITs with requirements, for example not working night shifts.

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

Trainers: Not covered.

FY/GPST RDITs: RDITs reported that they would raise any concerns about the quality of their training with their educational supervisor in the first instance. They were not aware of a RDIT forum or meeting where they could raise concerns as a group.

ST1-ST4 RDITs: Trainees reported that they would raise concerns about the quality of their training with their supervisor or TPD. They described a RDIT forum taking place once per month with representatives from each grade who gather feedback via trainee WhatsApp groups.

ST5-ST7 RDITs: RDITs agreed that they would raise concerns about the quality of their training with their supervisor or TPD. They reported that the trainee forum includes only STs and there is a representative for the junior tier rota and senior tier rota as well as an overall lead.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that raising concerns about patient safety is part of the culture of the department and RDITs are good at coming directly to trainers with any issues. Concerns about education and training are dealt with by supervisors and RDITs can also approach the consultant responsible for the rota if they require changes for educational reasons.

RDITs: RDITs reported that they would raise any immediate concerns about patient safety to the on-call team or unit lead and would feel comfortable doing this. Any less urgent issues they would report to their educational supervisor or TPD or record in their end-of-block feedback form.

2.19 Patient safety (R1.2)

Trainers: Daily multi-disciplinary huddles take place at which patient safety concerns are discussed. RDITs may or may not be present at these, but will be told what has been discussed. Trainers felt there was a global focus on patient safety and a culture of reviewing data, for example incidence of stillbirths, for team learning.

RDITs: RDITs would have no concerns about their friend or relative being treated in this department and felt their senior colleagues were very competent.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4)

Trainers: Trainers reported that generally they would not ask a RDIT to meet with a patient in a complaint situation, but would want them to gain practical experience of de-briefs while being supported by a consultant. Consultants attested that the support available within the department after adverse incidents is invaluable for both consultants and RDITs.

FY/GPST RDITs: RDITs felt that there was good support around adverse incidents with clinical situations being used for learning in a blame-free environment. RDITs did not have experience of communicating with patients when something had gone wrong with their care.

ST1-ST4 RDITs: RDITs described experience of being supported by the on-call consultant following adverse events by way of reviewing the event with them and being offered access to other resources such as support groups if wanted. RDITs reported that incidents were reviewed by the team and discussed at risk management meetings which they could attend. They also received feedback on datix reports when submitted. In terms of communicating with patients after something has gone wrong, RDITs described either shadowing a consultant doing this or having the support of a consultant whilst speaking to the patient themselves.

ST5-ST7 RDITs: RDITs reported that they had received good informal support through their supervisor when they had been involved in adverse events. They reported there are good opportunities to learn from incidents through risk management meetings and learning points are disseminated either to individuals or to all staff as required. RDITs also noted that they can submit datix reports and they receive feedback on these. RDITs reported that they are invited to be part of de-brief conversations with patients for their own learning but are supported by consultants during these.

3. Summary

Is a revisit required?	Yes	No	Highly Likely	Highly unlikely

Overall the panel found a cohesive department with excellent training opportunities and a high level of concurrence between the perceptions of trainers and RDITs. The panel were particularly impressed by the department's responsiveness to feedback, the personalised learning opportunities available and the culture of team learning from incidents. Some areas where improvements could be made were suggested, however the panel had no significant concerns regarding the training environment in the department. Due to the convergence between the survey data and the experiences described during the visit the Deanery team will continue to monitor the data associated with the department over the coming months.

Positives

- The panel found a group of engaged trainers who prioritise training.
- RDITs are also engaged in their training and in the overall running of the department and work co-operatively with the trainers to effect change.
- Induction is working very well and the improvements made recently appear to be effective.
- Work to improve and personalise the rota has been effective ensuring that training needs and curriculum competencies are met.
- Multi-professional work on culture has been constructive and appears to be bearing fruit.
- It was clear that the trainers and management team listen and respond to feedback.
- Gail Littlewood was praised by both trainers and RDITs as a very helpful and effective TPD.

- Feedback after adverse events and team learning from incidents is robust.

Negatives

- The panel felt the department could consider how local teaching can be better protected, particularly for FYs and GPSTs.
- The department could consider how handover could be used more effectively as a learning opportunity.
- The RDIT committee is very effective for STs to give feedback, however it appeared that FYs and GPSTs were not involved in this.
- Some RDITs have issues getting workplace-based assessments completed so work should continue to ensure that all members of the team complete tickets in a timely manner.

4. Areas of Good Practice

Ref	Item	Action
4.1	The use of a Teams channel to store information from induction has been a useful innovation to ensure RDITs have easy access to essential information which they might not remember.	
4.2	The appointment of a Workplace Behaviour Champion and introduction of Civility Saves Lives sessions appears to have contributed to cultural change in the department.	
4.3	The use of risk management meetings to discuss and learn from adverse events, as well as identifying areas of good practice, is both educational and supportive for RDITs.	

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	Consideration should be given as to how access to teaching could be improved, especially for FYs and GPSTs.	
5.2	The department could consider how handover could be used more effectively as a learning opportunity.	
5.3	Consideration should be given to inclusion of FYs and GPSTs in a RDIT forum.	
5.4	Work should continue to ensure that all tickets for workplace-based assessments are completed in a timely manner.	

6. Requirements - Issues to be Addressed - None