Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	9th July 2025	**Level(s)**	FY, GPST and ST
Type of visit	Triggered	**Hospital**	Ninewells Hospital
Specialty(s)	Obstetrics & Gynaecology	**Board**	NHS Tayside

Visit panel	
Mr Brian Stewart	Visit Chair - Associate Postgraduate Dean – Quality
Dr Shiona Coutts	Training Programme Director
Dr Jeremy Goss	Resident Doctor in Training Associate
Mrs Natalie Bain	Quality Improvement Manager
Ms Sarah Summers	Lay Representative
In attendance	
Ms Claire Rolfe	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Diagnostics, Paediatrics and Obstetrics & Gynaecology	
Lead Dean/Director	Dr Alan Denison and Dr Marion Slater	
Quality Lead(s)	Dr Alastair Campbell Mr Brian Stewart	
Quality Improvement Manager(s)	Miss Gillian Carter Miss Helen Pratt	
Unit/Site Information		
Non-medical staff in attendance		
Trainers in attendance	16	
Trainees in attendance	1 FY1, 2 FY2, 2 GPST, 10 ST	

Feedback session: Managers in attendance	Chief Executive		DME		ADME	X	Medical Director		Other	X

Date report approved by Lead Visitor	17th July 2025

1. Principal issues arising from pre-visit review:

Following the Quality Engagement Meeting (QEM) meeting held on the 22nd of May 2025, it was agreed that the best course of action would be to undertake a Deanery visit. The purpose of this would be to speak to the Resident Doctors in Training (RDITs) and trainers within the department to form a clearer view of the issues experienced in relation to both the educational environment and culture and be able to better support the department towards improvement. This visit would lead to the formation of objectives which the Deanery team would work with the site to achieve.

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.

Departmental Presentation: The panel would like to thank Dr Roselyn Mudenha for her very detailed presentation and the team for the work that went into it. The presentation provided an overview of the organisation and ethos of the department overall. The presentation detailed the areas of good practice, as well as the challenges faced by the department.

2.1 Induction (R1.13):

Trainers: The trainers reported that there has been a QI project completed by a Resident Doctor in Training (RDiT), that has improved induction overall. It is now a dedicated 1-day induction programme, with feedback surveys and include Foundation orientation to the department. It is highlighted that most Obstetrics and Gynaecology (O&G) RDiT's begin in ST1 and will likely only have one induction throughout their training at Ninewells Hospital. The trainers state that RDiT are made aware that it is a consultant-led service and they will get the information required for beginning in post and will find on the job training more useful in practice. The trainers highlight that the most recent feedback from the GP and FY cohorts was positive. It was gathered from the presentation that the department are hoping to appoint a Postgraduate Education Lead who will oversee induction, gather feedback and create an orientation week with a structured programme.

FY/GP RDIT's: All RDiT's reported having an induction to the department, and those that missed it were given a brief follow up. Induction was described as comprehensive and prepared the RDiT's for beginning in post.

ST RDIT's: The ST RDiT's reported that there is a new induction process in place and it is working well. All RDiT's received an induction when starting in ST1 and there is no other induction required.

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

Trainers: The trainers report that regional teaching is held jointly with the South-East training programme. It is stated that attendance at this recently has been poor, with verbal feedback from the RDiT's feeling that they were not welcome at the teaching. The trainers emphasise that the rota impacts the RDiT's ability to attend teaching, due to the high number of RDiT's that are Less than Full-Time Training (LTFT), zero days and annual leave. There is a lot of areas in the department to cover and with the limitations of the rota, it can be difficult to ensure that the RDiT's attend teaching. The trainers highlight that the feedback about the national teaching programme has been overwhelmingly positive. The trainers state that they are looking at solutions to improve departmental teaching, however there is no one single day that is good to provide the teaching, and there is no support to have the teaching bleep free. The challenge is trying to balance time with key learning opportunities. The department hope that with the appointment of the local education lead that they can implement dedicated multi-professional teaching and a published teaching timetable. Also, they hope to have a recorded and archived library of teaching.

FY/GP RDIT's: The RDiT's reported that there is limited local teaching available to them. It is due to be held on a Monday; however, the rota constraints and consultant commitments make it very difficult to attend. GPST's are able to attend their regional teaching and the department are supportive of this. The FY's in post have been able to attend most of the Deanery led teaching.

ST RDIT's: The RDiT's reported that there is three-tiered core teaching system in place for the East region programme. There are national teaching that is described as excellent and there is flexibility in place to take study leave at a later date to watch the recordings. There is local teaching provided that can be variable when it is held due to staffing, consultant workload and rota constraints. It was noted that a lunchtime teaching was trialled, but it was not attended well. Finally, there is Deanery led

teaching that is combined with the South-East region and held in Edinburgh. The RDiT's find it difficult to attend this in person, due to travel time, expense and rota constraints. They note that is better attended online, although this is not always possible due to the practicality of the specialty in general.

2.3 Study Leave (R3.12)

Trainers: The trainers note that they do try to approve study leave requests, however, the number of people who are off can affect the ability to approve study leave. There was some indecision between the group as to what study leave can be used for.

All RDIT's: The RDiT's reported no concerns with applying for study leave. The department are supportive of approving the leave, where possible with appropriate notice.

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

Trainers: All trainers reported that they have dedicated time in their job plan to undertake their educational roles. They have differing dedicated time depending on the number of trainees that they supervise. It is noted that it also recognised in the department when more time is required for RDiT's. The trainers also state that there is a good handover from the Training Programme Director (TPD) about the RDiT.

FY/GP RDIT's: The RDiT's reported meeting with the educational supervisor (ES) an appropriate number of times and these meetings are supportive.

ST RDIT's: Most RDiT's report meeting regularly with their ES both formally and informally and find the trainers supportive. Some RDiT's note that it can be challenging to meet with their ES due to timing but do eventually have meetings.

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: The trainers report that there is an on-call rota. If there are any concerns, there is always a consultant available both during the day and night and RDiT's are aware of who to contact. The trainers are not aware of any instances of RDiT's working beyond their competence as they have a

strong consultant presence. The trainers highlight that they support the RDiT's through the transition from ST2 to ST3 despite not being required to by NHS Education For Scotland (NES)

FY/GP RDIT's: The RDiTs have expressed concerns about being tasked with responsibilities that exceed their level of competence. In particular, when assigned to Maternity Triage, they often find themselves making clinical decisions they are not confident in, and report feeling pressured by midwives to undertake duties beyond their training. While most RDiTs understand the appropriate channels for escalating concerns, immediate support is often limited to phone consultations. This lack of immediate support leaves them feeling vulnerable in the triage setting. Although consultants are described as approachable, their availability is limited due to the high demands of their workload.

ST RDIT's: The ST RDiT's state that feel well supported by their senior colleagues and do not have to cope with problems beyond their competence. They note that the consultants are supportive and accessible, but the main challenge is the sheer volume of the workload and there are notable exceptions to some consultant providing support when it is busy. There are great challenges with the rota and it would be preferable to have more people covering triage.

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

Trainers: The trainers report that they don't believe the RDiT's are able to attend a satisfactory number of specific learning experiences such as clinics and time in theatre. They note that this is due to the rota constraints. It is explained that there are many clinics running in the department, however, the RDiT's are unable to attend for several reasons. The trainers report that the rota is designed by a RDiT and they do their utmost to allocate to educational opportunities. The trainers express that this is an area that requires improvement, with consultant oversight of the rota. It is stated that there are plans in place to try and address this quickly. The trainers highlight that they have never had trainees not able to achieve their curriculum competencies, however, if there is a particular competence they are unable to achieve in the department, they are supportive of RDiT's gaining this competence elsewhere. The trainers feel that the RDiT's would spend limited time doing tasks that do not support education, as they have a phlebotomy service on the ward and most midwives will also take blood. An ECG technician also supports the gynaecology department.

FY/GP RDIT's: The RDiT's stated that although they are getting access to theatre opportunities, there are no opportunities to attend clinics, with little time for self-directed learning. The RDiT's note that when they are in triage, it is for service provision and it doesn't provide any educational benefits.

ST RDIT's: The RDiT's report that they can find accessing Special Interest Training Modules (SITM's) challenging. It is highlighted that a lot of issues stem from the rota concerns and funding issues for clinical fellows. There are times when people are covering sick leave during their SITM sessions. It was noted that there are discussions about going to out with NHS Tayside for specific learning opportunities, but this is not formalised or in place. The RDiT's state that service provision gaps are having a detrimental impact on training. It is emphasised that RDiT's have less access to clinics compared to previous years in the programme. They feel they require more exposure to out-patient and ante-natal clinics.

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

Trainers: The trainers report that RDiT's are able to complete their curriculum requirements and will support them to do so.

FY/GP RDIT's: The RDiT's reported that they are able to complete their curriculum requirements and they can easily complete work-place based assessments (WPBA's). In Gynaecology there are the opportunity to discuss and learn from the cases. It is noted that there is no administrative time to complete portfolio work, therefore, this is done in the RDiT's own time.

ST RDIT's: The RDiT's report that it can be variable getting assessments completed. The majority of consultants are approachable and engaging with WPBA's, others are less proactive.

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

Trainers: Not formally asked, no issues raised in connection to this at the QEM.

All RDIT's: Not formally asked.

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

Trainers: Not formally asked, no issues raised in connection to this at the QEM.

All RDIT's: Not formally asked.

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: The trainers report that the RDiT's receive feedback both formally and informally and it is always given through a constructive conversation to ensure that there is learning from it. The trainers are sensitive to how and when feedback is given to the RDiT's, particularly following an adverse outcome. Some trainers note that when a GPST Registrar is involved then they would take the time to include their supervisor about the feedback given.

FY/GP RDIT's: The RDiT's reported that there is limited feedback given on clinical decision, unless there are concerns raised from the decision. The RDiT's feel that feedback is very segmented and workload dependant. When feedback is given, it can be mixed, with some giving constructive feedback and other times little effort is given to it.

ST RDIT's: The RDiT's report that feedback is mostly given in an informal setting. It is highlighted that the RDiT's feel they are given a good amount of feedback on case-by-case basis on labour ward and gynaecology on-call, with most consultant happy to provide feedback when asked. However, it is usually given verbally and informally.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: The trainers report that there is a monthly consultant meeting and a O&G staffing meeting, which would link in with any staffing concerns. A RDiT representative would attend the consultant meeting to highlight where they are seeing any challenges and the trainers feel that this has been useful to date. In addition to the representative, there is also a postgraduate trainee lead who also highlights any concerns that the RDiT's would have. This is a committee where they can feedback any concerns to both RDiT's and management. The trainers state that there was a previous forum for

consultants and RDiT's to feedback on each other's performances, but it would require to be reformatted to ensure that one person does not have responsibility for it.

FY/GP RDIT's: The RDiT's note that they are aware of monthly consultants meeting, where a representative attends and can raise any concerns they may have. It is also noted that there is a feedback box in the green room, any suggestions for this can be written anonymously and discussed at the consultant meeting, however there is no feedback from the consultant meeting about anything submitted. All RDiT's are aware that they can speak to their ES formally and informally. However, it is stated that there is no structured process other than a general conversation.

ST RDIT's: The ST's report that they can feedback any concerns they have to their ES. It was also noted that there was a previous forum project where RDiT's and consultant can give each other feedback that would be beneficial to put back in place. The ST state that there is a trainee representative that would attend the monthly consultant meeting, but there is limited feedback from this.

2.12 Culture & undermining (R3.3)

Trainers: The trainers report they believe the most important thing is that the RDiT's feel that the consultant are approachable to be able to raise any concerns that they may have in this area. The trainers have all completed their mandatory modules and there is a workplace behaviour champion. The trainers are only aware of instance of improper behaviour and there were processes in place to address this. The trainers believe that there are appropriate process in place for RDiT's to escalate any concerns they may have, but they highlight that they perhaps can be clearer.

FY/GP RDIT's: The RDiT's report that due to the way the department operates, that they don't spend a lot of time working with those above them, but the junior tier are very supportive. The RDiT's note that all the department are supportive, it is accessibility that causes concern. There were instances where RDiT felt undermined following a period of monitoring, but overall, it's an enjoyable experience. The RDiT's are aware of how to raise concerns and they feel they are able to directly talk to someone in the department with any issues they would have.

ST RDIT's: It is reported that the vast majority of consultant are very supportive but there are comments noted that handover can be used as an opportunity to undermine people in front of the wider multi-disciplinary team (MDT). It is also described that the RDiT are acutely aware of the negative interface between consultants, which can negatively impact the training environment for all.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The trainers report that there are challenges with the rota and they may have eroded opportunities, but there is a plan in place to address this and they hope to improve in this area.

FY/GP RDIT's: The RDiT's report that the rota is challenging and there are both long term and short gaps not being covered with locums. Due to the senior tier rota being quite tight and stretched, the workload for the junior tier is immense and leads to the RDiT's feeling exhausted. The RDiT's have highlighted their concerns to management and the number of RDiT's who LTFT were used as an explanation, rather than management working towards a solution.

ST RDIT's: The ST group report that although there are no gaps on the rota, long-term sick leave, maternity leave and LTFT impact the ability to cover all the areas efficiently and effectively. The rota in theory accommodates for learning opportunities, however, the RDiT's are often pulled away to cover sick leave at short notice. The group state that a 10-person whole time equivalent (WTE) may not be enough to cover their increasing workload, on-call commitments, learning opportunities whilst allowing for leave and teaching to be taken. The group note that they are not seeing emergency gynaecology like previously, as it is more managerial tasks rather than clinical tasks. The RDiT's feel that the introduction of an ANP or a "disco shift" would help with the increasing workload across the unit.

2.14 Handover (R1.14)

Trainers: The trainers report that handover is held at 8am with the team and they prioritise cases here and move to the huddle by 8.30am. The department note that handover is structured and educational with a SBAR linked to it. The trainers note that there might be room for improvement with continuity of care, but it is safe for all involved.

FY/GP RDIT's: The RDiT's reported that in general that handover was safe and effective for all involved. There were some concerns about the process of handover discussion on labour ward, as they use rooms numbers instead of the patients name or CHI number. Most RDiT's felt this was unsafe for the patients involved. It was highlighted that handover takes place in the break room and they can be interrupted, or other people use the room when handover is taking place. The RDiT's feel that this time is not respected and requires to be more formal. There were concerns raised about the Gynaecology handover to the Hospital at Night team (HAN). Some RDiT were concerned that the only way to handover to HAN was via an email and they were unaware if it is acted upon, as it is the HAN teams policy to not reply directly to emails. It was found that RDiT's were staying past their shift end to attend the HAN handover in person, to ensure their patients were handed over safely.

ST RDIT's: The ST's reports that handover is safe and effective with the exception of HAN. The RDiT's state that there is not a structured handover to and from them. There is an email handover, but there is no acknowledgement from the team and it is concerning as to whether the handover is being received and actioned.

2.15 Educational Resources (R1.19)

Trainers: Not formally asked, no issues raised in connection to this at the QEM.

All RDIT's: Not formally asked, no issues raised.

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 formally asked, no issues raised in connection to this at the QEM.

All RDIT's: Not formally asked, no issues raised.

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 formally asked, no issues raised in connection to this at the QEM.

FY/GPST RDIT's: Not formally asked, no issues raised.

ST RDIT's: The ST's report that they can raise any concerns relating to the quality of training to their supervisors. The TPD organises the supervision for the RDiT's. It was noted that there was previously a college tutor in place, but management made the decision that this role was not required, therefore there is no one else they can speak with.

2.18 Raising concerns (R1.1, 2.7)

Trainers: The trainers report that they are approachable and RDiT's are able to come to them if they have any concerns. RDiT's can escalate any concerns to their ES, CS or the wellbeing champion.

All RDIT's: Not formally asked.

2.19 Patient safety (R1.2)

Trainers: Not formally asked, no issues raised in connection to this at the QEM.

FY/GP RDIT's: The RDiT's reported that if a friend or relative were to be admitted to the unit, they would have concerns due to the skills sets of the junior RDiT's covering triage. The RDiT feel that this is an issue affecting the NHS as a whole. The senior registrars are stretched and there are times when they are managing patients in two areas.

ST RDIT's: The RDiT's reports that they wouldn't have any concerns about the quality of care given to the patients. However, there are concerns about the staffing level in the department to be able to manage the workload. The group acknowledge that the care given to emergency cases is excellent, however, they do wonder if immediate care was given when they present as a non-emergency case, then perhaps there wouldn't become emergencies. The ST's emphasise that there is good teamwork in the department and they prioritise well, but there is concerns that there is not enough staff members to compete with the workload and long wating times.

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

Trainers: Not formally asked, no issues raised in connection to this at the QEM.

All RDIT's: Not formally asked, no issues raised.

2.21 Other

3. Summary

Is a revisit required?	**Yes**	**No**	**Dependent on outcome of action plan review**

Positive aspects of the visit:

- The panel was impressed with the induction programme, particularly the quality improvement initiatives undertaken to enhance its delivery. The induction has been well received by trainees and is highly commendable.
- It was reported that access to study leave is well supported, allowing trainees to pursue educational opportunities effectively.
- The panel was pleased to hear that trainers have dedicated time within their job plans to provide appropriate support to trainees, reflecting a strong commitment to education.
- Throughout the visit, Resident Doctors in Training (RDiTs) spoke positively about their ability to complete Workplace-Based Assessments (WPBAs). The consultant body were described as approachable and generally responsive in supporting these assessments.
- The Gynaecology department, in particular, was highlighted as being supportive and approachable, contributing positively to the training environment.
- The panel noted that the department benefits from a cohesive and supportive group of RDiTs who are clearly invested in contributing to the success of the training programme.
- Finally, the panel would like to acknowledge and express appreciation for the openness and honesty of those who participated in the visit. It is evident that there is a solid foundation of good work already in place, with ongoing efforts to drive further improvement.

Less positive aspects of the visit:

- The panel was informed that both local and regional teaching raised several concerns. RDiTs are facing challenges in attending scheduled teaching sessions. Additionally, the overall delivery of local teaching—from Foundation to Specialty requires significant improvement.
- The panel noted that staffing levels on the rota are impacting the ability to provide both adequate service delivery and the achievement of educational training objectives, for example, regular clinic attendance.
- Maternity triage has been highlighted as a concern by both junior and senior RDIT's. Junior RDiT's often feel exposed due to limited support, while senior RDiT's are overwhelmed by the demands placed on them. Ongoing staffing shortages are negatively affecting RDiT's experiences and may pose risks to patient safety. The board must provide greater support through improved rota planning.
- While the panel acknowledged the presentation outlining plans for a local Postgraduate Educational Lead, it was noted that there remains a need to distinguish educational responsibilities from those of the Training Programme Director. Appointing an additional individual to coordinate and allocate educational opportunities is essential to meet RDiTs' needs effectively.
- Overall, RDiTs reported that the environment is generally supportive and that senior staff are approachable when concerns need to be escalated. However, they also noted occasional instances of incivility, particularly during handovers. Additionally, tensions between consultants were observed, which at times made RDiTs feel uncomfortable.
- The overall handover process was reported to be effective; however, concerns were raised regarding the gynaecology handover, particularly involving the HAN team. RDIT noted limited engagement from the team when handing over patients during night shifts.
- There appeared to be some misalignment between the experiences of RDiT's and the perceptions of trainers. Some RDiTs reported feeling pressured being Less Than Full-Time (LTFT) training, as it was perceived to negatively impact the rota. This has contributed to a sense of tension and potential conflict within the team.

4. Areas of Good Practice

Ref	Item	Action
4.1	The induction programme is impressive and well received by all involved	
4.2	The Gynaecology department were praised by all group of RDiT's as supportive and approachable.	

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	n/a	n/a

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	There must be active planning of attendance of doctors in training at teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	9th April 2026	All
6.2	A regular programme of formal teaching should be introduced appropriate to the curriculum requirements for each cohort of resident doctors in training	9th April 2026	All
6.3	Ensure that service needs do not prevent trainees from attending clinics and other scheduled learning opportunities	9th April 2026	All

6.4	The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.	9th April 2026	All
6.5	Solutions must be found to address the concerns relating to maternity triage which may have non-intended consequences such as patient and trainee safety risks.	9th April 2026	All
6.6	A review of the role of the Training Programme Director and Educational Training Lead should be undertaken in the department to ensure clarity of roles and responsibilities. This includes both formal and informal roles.	9th April 2026	All
6.7	Handover arrangements must be reviewed, especially between HAN and the Gynaecology team.	9th April 2026	All
6.8	Relationships with the consultant – management interface must be improved. All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	9th April 2026	All