Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	20th June 2025	**Level(s)**	FY, ST
Type of visit	Triggered	**Hospital**	Royal Infirmary of Edinburgh
Specialty(s)	Neonatal Medicine	**Board**	NHS Lothian

Visit panel	
Mr Brian Stewart	Visit Lead – Associate Postgraduate Dean for Quality
Dr Joanna Chisholm	Training Programme Director
Dr Lisa Black	Foundation Consortium Lead
Dr Morag Campbell	College representative
Dr Aye Doris	Trainee Associate
Mr Eddie Kelly	Lay representative
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Ms Ashley Bairstow-Gay	Quality Improvement Administrator

Non-medical staff in attendance	3	
Trainers in attendance	8	
RDITs in attendance	FY: 1	ST: 5

Feedback session: Managers in attendance	Chief Executive		DME	√	ADME	√	Medical Director	
	Other: Quality and Safety Improvement Lead, Service Manager, General Manager, College Tutor, Clinical Lead							√

Date report approved by Lead Visitor	14th July 2025

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data from the 2024 National Training Survey (NTS) and Scottish Training Survey (STS), Neonatal Medicine at the Royal Infirmary of Edinburgh was identified as being in the bottom 10% of departments for survey data and therefore within scope for a Deanery visit. The specific concern identified was that the department was in the bottom 2% in the NTS for triple red flags (flags which have been red in a specific domain for the past 3 years). Of note, there was also a red flag for discrimination in the STS. No data was available for FYs on this occasion.

The most recent data has been included below for information. NTS data is from the 2024 survey while STS data is from the March 2025 data review so includes more recent surveys:

- NTS: Red flags for facilities, local teaching, regional teaching, supportive environment and workload. Pink flags for clinical supervision and educational supervision.
- STS All Trainee: Red flag for discrimination.
- STS ST: Pink flag for discrimination.

The Deanery panel wished to explore the above concerns as well as identifying any points 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 Judith Orme and colleagues for the informative presentation shared at the start of the visit which described the improvement work undertaken and ongoing within the department.

2.1 Induction (R1.13):

Trainers: Trainers reported that it is common that Resident Doctors in Training (RDITs) miss the initial induction date due to night shifts, however they ensure everyone receives an adequate

induction by liaising with those who organise the site's corporate induction and by providing a bespoke departmental induction to all RDITs. This is usually led by college tutors and covers Trak training. Additional sessions are organised as needed to ensure RDITs are comfortable.

RDITs: RDITs reported that they received a 2-day induction when new to the site and department, although this was not repeated for those returning for a second post in the department. They noted that returning RDITs received the same written information and a questionnaire about confidence, however there was no follow-up from this. RDITs felt that a refresher induction would be useful for those returning to the department.

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

Trainers: Trainers reported that local teaching is bleep free as specific consultants are identified to take bleeps during teaching. If a RDIT has not come forward to hand over their bleep, consultants will find them and release them for teaching. While holding bleeps they will complete both urgent and routine jobs to ensure RDITs do not come back to an unmanageable workload. Trainers noted that regional teaching covered Paediatrics only although they were trying to incorporate some Neonatal Medicine colleagues into the programme. They try to provide as much Neonatal Medicine teaching as possible within the department as well as protected 'step up' simulation days for ST2s.

RDITs: RDITs noted that they have protected local teaching on a Thursday afternoon and can usually hand over their bleep to a nominated member of staff. They reported it was more difficult to hand over their bleep when on the postnatal ward as they could not always find the postnatal consultant and found it hard to attend other local learning opportunities such as perinatal meetings. In terms of regional teaching, there was no agreed plan for RDITs to hand over their bleeps for this and generally they did not attend. Some STs were confused as they had been discouraged from attending regional teaching while working in Neonatal Medicine and tended to only attend if non-clinical. RDITs felt that it would be helpful if the department had more space to attend regional teaching via Teams and more support for attendance.

2.3 Study Leave (R3.12)

Trainers: Trainers reported that there was usually no issue with approving study leave if RDITs applied in advance, although it could be challenging when a lot of RDITs were off at the same time.

RDITs: RDITs reported that it was easy to obtain study leave and they could apply either before or after the rota had been issued.

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

Trainers: Trainers confirmed that they have Supporting Professional Activities (SPA) time in their job plan. They felt they had a good balance between supporting RDITs on the wards and time for supervisor meetings and other 1:1 support. They noted that they received a lot of helpful resources from the Scotland Deanery and the Health Board to support them in their supervision roles, including regarding support for International Medical Graduates (IMGs). During the ongoing period of change in the department they are also receiving specific mentoring from the DME/ADME. Trainers reported that they would find it helpful if they received information about RDITs with difficulties at the earliest opportunity to allow planning.

RDITs: RDITs advised that they had so far met their educational supervisor at the start and middle of the block. Some educational supervisors were outside the Neonatal Medicine team.

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 reported that they try to flatten the hierarchy in the department and encourage RDITs to call for help when needed. When RDITs start in the department they are given constant supervision and consultants review all patients with RDITs during ward rounds. As part of the recent departmental improvements the evening consultant shift has been extended so consultants are present until later and can support RDITs in making plans for the night. Trainers estimated that they stay overnight around 10% of the time and will always stay or return if required. Phone numbers for consultants are provided within the department and trainers reported that they encouraged RDITs to phone them at any time.

RDITs: RDITs reported that they had an initial meeting with their clinical supervisor and see them regularly in the department. They did not feel they had to work beyond their competence or experience as the senior tier were very accessible and they could always ask for help if uncomfortable doing something alone.

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

Trainers: Trainers felt most of the work done by RDITs was of educational value as they were usually involved in treatment planning and making clinical decisions. The only areas which they felt could be less educational were the jaundice and weight loss clinic and the large volume of discharge planning. They were looking at ways to reduce the administration burden of the jaundice and weight loss clinic by better utilising nursing staff. The extension of the evening shift and the greater number of RDITs working overnight were hoped to ease the administrative load of discharge planning.

RDITs: RDITs reported that the department was busy and there were a lot of opportunities to complete procedures, although there could be competition for less common procedures. The RDITs in attendance felt that most of their work was non-educational although they were content with the nature of their role. RDITs noted that this post was unusual as the postnatal shifts were high volume and less educational but poorly supported, whereas the Intensive Care Unit (ICU) was low volume and more educational whilst being very well supported. RDITs noted that they generally feel more comfortable in ICU than on the postnatal ward due to the higher level of support. RDITs thought the ST2 shift which involved learning to be a registrar was particularly educational.

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

Trainers: Trainers reported that they were both proactive and reactive in completing assessments and offer to complete assessments on the wards as well as responding to those sent via Kaizen. RDITs can put their names next to certain procedures that they require to ensure fair distribution. Trainers also try to offer unique leadership and acting up opportunities for sub-specialty RDITs.

RDITs: RDITs noted that they needed to be proactive in asking for assessments to be completed but generally had no issues obtaining them. They felt the easiest times to obtain assessments were when working out-of-hours or in ICU.

2.8 Adequate Experience (multi-professional learning) (R1.17) – Not covered

2.9 Adequate Experience (quality improvement) (R1.22) – Not covered

2.10 Feedback to RDITs (R1.15, 3.13)

Trainers: Trainers reported that they give feedback to RDITs while working with them on the wards, during ward rounds, at ICU catch-ups and at handover.

RDITs: RDITs reported that they could receive feedback when asking a senior colleague for advice or during the evening ward round, although they felt feedback was generally more reactive than proactive. The feedback they had received had been meaningful and constructive. RDITs noted that there was no formal de-brief process however they had experienced helpful informal de-briefs after resuscitations.

2.11 Feedback from RDIT (R1.5, 2.3)

Trainers: Following feedback from RDITs, informal feedback sessions have been introduced for RDITs with the college tutors. Any concerns raised at these meetings can then be taken back to the training education faculty or consultant operational faculty. They plan to introduce an option to join these sessions via Teams as some RDITs wish to have the option to join from home if not at work.

RDITs: RDITs were aware that they could give feedback via the NTS and STS, directly to their supervisors or via the meetings with the college tutors. Some struggled to attend the meetings with college tutors due to workload and acuity or due to working a high percentage of night shifts.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt that a positive culture is driven in the department by senior leaders. Consultants aim to be approachable and open about challenges as well as promoting positive social interactions through events such as coffee and cake. They felt they were proactive about ensuring RDITs got their breaks and were able to leave on time. Trainers noted that Paediatrics and Neonatal

Medicine have only recently been co-located and they are working on creating an integrated culture between the departments. In addition to creating a positive culture, trainers reported that they challenge incivility and have provided active bystander training within the department. Trainers had not received any reports of incivility this year, but had heard some last year. They noted that college tutors play an important role in addressing reports of incivility as RDITs are more likely to approach them informally.

RDITs: RDITs found their senior tier colleagues and most consultants to be very supportive and had mainly positive interactions in the department. Some concerns were raised regarding a lack of care in the language used by consultants during stressful periods and critical comments being made publicly at handover. There were also concerns regarding consultants being publicly critical of each other and frequent changing of management plans which had a negative impact upon patients as well as upon RDITs who had to explain changes to families.

2.13 Workload/Rota (1.7, 1.12, 2.19)

Trainers: Not asked.

RDITs: RDITs reported that their rota was targeted towards their curriculum requirements and varied by grade. They also had access to SPA time for administrative tasks or attending conferences, although this could be cancelled in cases of unexpected short staffing. RDITs found it easier to obtain procedures when their rota kept them in the same location for a few days rather than moving around frequently.

2.14 Handover (R1.14)

Trainers: Not asked.

RDITs: RDITs reported that there are morning and evening handovers in the High Dependency Unit (HDU) and in ICU with a consultant presence at the ICU handover. Handover in the postnatal ward was described as RDIT to RDIT and there was also a need to liaise with midwives. RDITs noted there was no formal handover involving the Obstetrics and Gynaecology team so they could sometimes face unexpected admissions.

2.15 Educational Resources (R1.19) – Not covered

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

Trainers: Trainers reported that they offer both clinical and emotional support to RDITs and their promotion of open relationships within the department helps RDITs feel able to ask for help when needed. Trainers were aware of the services available to them in supporting RDITs, for example the Trainee Development and Wellbeing Service (TDWS) within the Scotland Deanery. As mentioned previously, trainers felt they could give better support if they had more information about RDITs with difficulties prior to their arrival.

RDITs: Not asked.

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) – Not covered

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked.

RDITs: RDITs felt that consultants would be very receptive if they contacted them about any patient safety concerns.

2.19 Patient safety (R1.2)

Trainers: Not asked.

RDITs: RDITs noted that any updates about patient safety are circulated by email to inform the whole team and they use datix reports to learn from adverse incidents. A formal safety brief is in place for nursing staff but not for doctors. RDITs sometimes felt nervous overnight when the most senior doctor could be at ST4 level, however they noted that consultants will stay overnight if needed. They did not feel unsafe working in the department. RDITs did have concerns relating to nursing staffing and noted

that during the week of the visit there was a day when the ICU had 8 nurses missing. They noted that the consultant had been made aware of this and had sought a solution.

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

Trainers: Trainers advised that adverse incidents are reported via datix and RDITs can attend a weekly whole team meeting to discuss these. Trainers felt that the process emphasised service learning rather than targeted blame. RDITs are also invited to shadow consultants when they are discussing adverse events with patients.

RDITs: As above, RDITs reported that they were encouraged to complete datix forms to record adverse events and consultants were proactive in highlighting areas where a datix should be completed.

3. Summary

Is a revisit required?	**Yes**	**No**	**Dependent upon outcome of Action Plan Review Meeting**

Positives

- Significant positive changes had been made in the department over the past year and this was recognised and appreciated by RDITs.
- The panel noted an open culture in the department and honest dialogue between trainers and RDITs, for example the culture surrounding reporting and learning from adverse incidents or near misses.
- Local teaching has been improved since last year and is widely accessible.
- Working in the clinical environment was generally a positive experience.
- RDITs had good access to study leave.
- The RDITs in the department were a cohesive and supportive group.

Negatives

- Whilst access to local teaching was commended, RDITs did not have access to regional teaching which is an essential part of their curriculum. This is important for Neonatal Medicine sub-specialty RDITs as the regional teaching programme maps to the generic Paediatric curriculum which they need to evidence.
- Trainers and RDITs had a mismatched perception of supervision on the postnatal ward with RDITs sometimes feeling unsupported in this environment.
- Some cultural issues remained, particularly in terms of inter-consultant friction and open criticism of colleagues.

4. Areas of Good Practice

Ref	Item	Action
4.1	The department has responded proactively and comprehensively to the issues raised in the NTS and STS surveys in 2024 and significant improvements have been seen as a result. RDIT feedback has been utilised in this process.	

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
	N/A	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	RDIT cohorts in scope
6.1	Barriers preventing RDITs attending their dedicated regional teaching must be addressed.	20th March 2026	FY, ST
6.2	The department should ensure that there are clear systems in place to provide supervision, support and feedback to RDITs working on the postnatal ward.	20th March 2026	FY, ST
6.3	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	20th March 2026	FY, ST, Trainers