Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	28th July 2025	**Level(s)**	FY, Core, Specialty
Type of visit	Triggered Visit	**Hospital**	Royal Hospital for Children & Young People
Specialty(s)	Paediatric Surgery	**Board**	NHS Lothian

Visit panel	
Dr Kenneth Lee	Visit Lead & Associate Post Graduate Dean – Quality
Mr Martyn Flett	Training Programme Director
Dr Chetana Patil	Foundation Programme Director
Dr Jeremy Goss	Trainee Associate
Helen Adamson	Lay Representative
Fiona Paterson	Quality Improvement Manager
In attendance	
Susan Muir	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine, Anaesthetics/Intensive Care Medicine/Emergency Medicine & Surgery	
Lead Dean/Director	Professor Adam Hill	
Quality Lead(s)	Dr Reem Al Soufi, Dr Alan McKenzie, Ms Kerry Haddow, Dr Fiona Drimmie & Mr Phil Walmsley	
Quality Improvement Manager(s)	Jennifer Duncan and Vhari MacDonald	
Unit/Site Information		
Non-medical staff in attendance	3	
Trainers in attendance	5	
Trainees in attendance	5 x FY, 4 x ST	

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

Date report approved by Lead Visitor	14th August 2025

1. Principal issues arising from pre-visit review:

Paediatric Surgery training has not been visited since a programme visit in 2018, following concerns raised at the Surgical review panel. Training moved from Royal Hospital for Sick Children to the Royal Hospital for Children and Young people in March 2021.

Following the March 2025 data review the panel decided to trigger a visit to the unit due to concerns raised via an FPD enquiry which sighted rota issues, challenging nurse interactions, lack of rest facilities, burden of non-educational tasks, limited support and play therapists overstepping boundaries. The visit aims to further investigate issues highlighted and to advise on steps towards addressing and resolving them where required.

Review of Survey Data:

NTS Post Trend 2024

The overall post 1 year trend data shows a red flag for Educational Governance Facilities and Regional teaching. There is a green flag for Workload. Significant change indicators (SCI) present for Educational Gov.

NTS Programme results for FY1 in 2024 – 1 red flag for Feedback, All other indicators are white. N=4

NTS Programme results for FY2 in 2024 – Adequate Experience, Educational Supervision and Induction are pink. All other indicators are white. N=3

NTS Programme results for CST in 2024 – Unfortunately, less than 3 trainees completed the survey.

NTS Programme results for Specialty Trainees in 2024 – 10 red flags for Adequate Experience, Educational Governance, Facilities (triple red), Induction, Overall Satisfaction, Regional teaching, Reporting Systems, Rota Design, Study Leave and Supportive Environment. Clinical Supervision OOH is pink and workload green. N=6

N.B At the time of review the 2025 NTS data was under embargo and not able to be shared. The panel note the improvement to the specialty doctors data going from 10 red indicators to 3 reds and 1 pink. The FY data has also reduced from 3 to 1 pink indicators.

STS Trend 2025

STS Post Trend 2025 – All indicators are white, bar Rest Facilities which are red

Core: <3 completed the 2025 survey. Aggregated data All white bar 2 lime for Clinical Supervision & Handover. 1 positive FTC re senior led accessible leadership and positive culture.

FY: N=7 All indicators are white bar Handover which is light green and a red for Rest Facilities. Positive SCI's for Educational Environment & Teaching, Induction, Team Culture and Travel. 3 Negative FTS re Rota, Workplace Culture, Lack of communication from specialties transferring into ward and concern re post not contributing to development.

Specialty: N=5 Educational Environment & Teaching, Equality & Inclusivity & Rest Facilities are red. Catering Facilities pink, Clinical Supervision is lime. All other indicators are white.

Departmental Presentation: The visit team would like to thank Mr Phil Hammond, Clinical Lead & Consultant Paediatric Surgeon for the informative presentation which gave a detailed overview of the department, challenges faced and work undertaken to address issues. Information from the presentation has been incorporated in the report below.

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.

2.1 Induction (R1.13):

Trainers: Both hospital and departmental inductions are provided. The induction programme for all doctors in training comprises online modules and a face-to-face induction. The initial induction is

delivered over the first few days of the rotation focusing on essential areas such as common clinical presentations, condition management, and escalation protocols. Further sessions are scheduled over subsequent weeks to address additional clinical and operational topics. Supporting resources include induction handbooks for FY and Specialty doctors which are updated regularly.

A proposal to invite FY1 doctors to attend the department prior to their official start date is being trialled in the upcoming rotation, with feedback to be collected thereafter.

Efforts are made to ensure that FY doctors are not scheduled for night shifts immediately prior to induction to facilitate attendance. Rota planning accounts for induction attendance, and doctors who have already completed induction are appropriately scheduled. Specialty doctors who are new to the department typically have their on-call duties deferred for the first two weeks to allow them to shadow. If any resident doctor in training (RDIT) is unavailable for induction, alternative arrangements are made. Trainers were not aware of any instances of RDITs being unable to attend.

Feedback is sought and addressed through informal discussions. No significant concerns have been raised. Trainers reflected that pre-recording elements of the induction would enhance accessibility and flexibility.

FY1/FY2: All new staff received a comprehensive hospital induction covering a wide range of topics, including prescribing practices and safeguarding. Significant delays were experienced in issuing access cards due to a system problem, which remained unresolved for approximately 6 weeks. During this period, staff were provided with three shared badges to access clinical areas. Attendance at the departmental induction was varied with only 3 FY's scheduled on shift. Of those who did attend 1 was called out to assist in theatre and another was interrupted frequently whilst holding the on-call bleep. FY's told us they received a handbook but that some areas require updating. The induction programme spanned two weeks, but some staff missed sessions due to annual leave. Although the timetable was circulated, staff only received their rota three weeks prior, which affected planning. In some cases, individuals were allocated to induction sessions but were not scheduled to be on shift according to the rota. Suggestions to improve the induction included providing information on roles and responsibilities of surgical nurse practitioners and increasing attendance.

ST: All received both hospital and departmental induction. New starters do not commence on-call or night shifts immediately, allowing time to settle into the role. They felt well-equipped to begin work, with login details and ID badges issued at the start of their post. RDIT's work across several hospital sites and told us passes were not available in advance for other sites. This required staff to organise access on their first visit.

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

Trainers: Departmental teaching for all cohorts is scheduled for Monday afternoon. Attendance can be limited due to rota schedule and at times only 1 or 2 RDITs can attend. To help address this for the specialty doctors the department have committed to a British Association Paediatric Surgeon funded national post graduate virtual learning environment initiative to cover the syllabus. FY doctors attend structured hospital teaching sessions on Tuesday and Thursday mornings, which focus on topics specific to their training level. They also attend a half-day Paediatric Life Support training which is delivered early in the rotation, equipping them with confidence in managing life-saving scenarios**.**

Specialty regional teaching is less defined, East and West regional programmes convene annually for topic-specific sessions. A National Training Day is scheduled early in the year to allow for consultant-led teaching, with rotas adjusted to ensure attendance.

Core doctors follow a separate teaching programme, including both regional and national training days. These are identified early and protected to ensure attendance.

FY1/FY2/Core/ST: Departmental teaching time is scheduled on Monday afternoons from 14:00 to 16:00, following the radiology meeting from 12:45 to 14:00. Typically, there is an FY presentation, teaching from registrars and general ward discussions. Attendance is often impacted by rota commitments such as pre/post nights, on call or annual leave. Although time is allocated for higher surgical teaching, sessions are not consistently arranged. The previous rota allowed for more consistent teaching attendance, whereas the current schedule presents frequent barriers. The teaching session lasts nearly three hours, during which essential clinical tasks such as discharge letters accumulate for the junior tier. Over the past 4–5 months, some FY's have only been able to attend two sessions whilst their specialty colleagues estimated attending around 50% of sessions.

FY doctors noted no barriers to attending their specific teaching sessions. Regional teaching for specialty is held biannually**;** attendance is prioritised for RDIT's and strongly encouraged.

RDIT's told us there is a strong culture of informal teaching, with consultants and registrars regularly engaging RDIT's in case-based discussions. This was especially valued by specialty trainees.

2.3 Study Leave (R3.12) Not asked

2.4 Formal Supervision (R1.21, 2.15, 2.20, 4.1, 4.2, 4.3, 4.4, 4.6) Not asked

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 staff can differentiate between the different levels of RDIT's using coloured ID badges. They were unaware of any difficulties in identifying training grades as they cover different roles. Clinical and Educational Supervisors are detailed at induction along with escalation policies. Handover also provides the opportunity to reiterate who to contact.

Trainers were unaware of any instances of RDITs working out with their level of competence as they are encouraged to contact senior staff at all times. They noted RDITs concerns regarding out of hours support from subspecialties and it is hoped that joining the hospital at night team will create a more supportive team feeling.

FY1/FY2: All were aware of supervision arrangements and escalation pathways. Almost all told us they had worked out with their level of comfort. OOH work when the registrar is not resident can be challenging and they detailed instances of dealing with patients who wish to self-discharge with no care plan in place or seeking support in an emergency from subspecialties such as plastics, ENT and orthopaedics. The paediatric general surgical team is consistently supportive and escalation protocols are clear.

ST: They always know who to contact and described the consultants as highly accessible, approachable, and supportive. There have been no instances where they felt they managed situations beyond their level of competence. They highly commended senior staff for their willingness to provide guidance and maintain a safe and supportive learning environment.

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

Trainers: Trainers confirmed they are aware of curriculum requirements. All involved in supervision engage with the ISCP website and keep updated on TURAS for FY requirements. Some attend ARCP for both core and national reviews. Any changes to training requirements are communicated via appropriate channels.

For specialty doctors attendance at learning opportunities such as clinics or theatres are monitored in collaboration with the Training Programme Director (TPD) to ensure ARCP requirements are met. Work place based assessment (WPBA's) are reviewed at both the midpoint and end of the training year to ensure progress and identify areas for development. Trainers acknowledged it can be difficult to provide 3 theatre and 2 clinic sessions per week since the change in rota has increased numbers of doctors on the rota without an increase in activities. Adjustments have been made, such as pairing senior and junior RDIT's to optimise learning. Certain index cases and ensuring competence in doing so can also be hard to achieve and there is agreement with NHS Lothian that RDIT's can attend other specific lists as long as they stay within agreed hours.

FY doctors meet with supervisors at the beginning of each post to agree learning objectives. These are reviewed at the midpoint and end of the training year. If objectives are not met by the midpoint a plan is put in place to help achieve. Theatres and clinics are not assigned on the rota but FY's are welcome to attend all learning opportunities and are assigned a 'blue' week on the rota which is intended for learning. They are encouraged to take responsibility for their own learning and seek opportunities aligned with their interests. There will be an extra FY doctor on the rota from August rotation and it is hoped this will increase availability to attend training opportunities.

FY1/FY2: All can achieve learning outcomes with no issues. They do not attend clinics but told us there are opportunities to attend theatre when on call or working within the day case unit. Although learning opportunities are not scheduled, they are encouraged to attend. FY doctors estimated that more than 50% of their time was spent completing what they considered non-educational tasks.

ST: Due to the smaller patient case load in Edinburgh, RDIT's reflected it can be challenging to complete some index procedures. The change in the rota has increased competition for theatre

cases. When junior and seniors have been paired on the same theatre list they felt this diluted their training experience. There have been occasions where ST's have had no theatre lists scheduled and rota constraints prevented their attendance at available lists.

2.7 Adequate Experience (assessment) (R1.18, 5.9, 5.10, 5.11) Not asked

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

2.9 Adequate Experience (quality improvement) (R1.22) Not asked

2.10 Feedback to trainees (R1.15, 3.13)

Trainers: Trainers recognise feedback as a vital component to the learning environment helping assess progress and identify future learning needs. All trainers have completed feedback courses available through the RCS. ST's are attached to a named consultant throughout their post to allow tracking of progress and continuity. At the start of clinic or theatre they identify learning objectives for RDIT's. Since August of last year, multi consultant reports have been conducted twice per placement, feedback is provided at a consultant level and subsequently discussed directly with the RDIT's.

FY1/FY2 Doctors: They reported receiving informal feedback but this can be dependent on who they are working with. When received, feedback is useful.

ST's: ST's reported they receive good feedback and described approachable consultants who deliver constructive and meaningful feedback with excellent attention to training.

2.11 Feedback from trainees (R1.5, 2.3)

Trainers: Representative registrars from each region attend ARCPs providing an opportunity to discuss concerns from the group anonymously. Informal meetings are held with RDIT's to encourage open dialogue regarding any concerns or suggestions for improvement. RDIT's are also supported in raising issues outside of their immediate department if necessary.

FY1/FY2: FY's commented that they could provide feedback on their training within survey's or sessions like the visit. They were not aware of any trainee forum but could speak with the registrar doctors.

ST's: They were unaware of any formal mechanism to feedback to their trainers. Following rota concerns they requested a meeting with the ADME and chief registrar. ST's perceive a lack of management support.

2.12 Culture & undermining (R3.3)

Trainers: As a group the consultants are all approachable and supportive. Regular informal meetings, such as coffee catchups outside the hospital environment, provide an opportunity to raise concerns and receive guidance. A recent incident involving bullying outside the department was flagged through the "We Care" initiative which was dealt with appropriately helping to reinforce a culture of support and accountability.

FY1/FY2/Core/ST: RDIT's describe the general paediatric surgery team as supportive and welcoming. They reported no additional concerns and felt well integrated into the department. There were no reports of any undermining activity similar to those mentioned in the FPD enquiry.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: There had been significant disengagement and dissatisfaction within the department regarding the locally developed rota, which deviates from the NHS Lothian standard. The rota is compliant for a team of 8 but has been operating with only 6 for over a year. This has led to a diluted elective experience and exhausting work patterns for RDIT's, contributing to a breakdown in trust between senior RDIT's and management. Despite efforts to raise concerns through support surveys and "We Care" initiatives, which highlighted the negative impact on day-to-day wellbeing, ST's feel their feedback has been met with a "brick wall", causing further frustration. While the situation has improved compared to a year ago and the current rota is compliant, the core issues remain unresolved. There is a strong desire among ST's to return to a 24-hour rota, which is seen by them as more manageable.

The department have implemented several changes to help improve the rota including:

- Additional FY on rota from August 2025
- Core doctor due to provide additional tier alongside on call registrar, moving from the FY rota.
- Recruitment of a Clinical Fellow which focus on quality improvement/medical education
- Recruitment of Consultant Education Lead (0.5PA)
- Funding agreed to recruit Consultant Paediatric Surgeon

FY1/FY2: There had been 1 instance of FY sickness to which the group had been asked to organise cover amongst themselves and told locum rates or time in lieu would be provided. Initially, they expressed a willingness to provide cover however, they later withdrew their offer upon learning that the rates offered did not meet their expectations. The group told us they felt this had been handled poorly. Some of the shifts were covered by a specialty doctor from another department but this resulted in an increased workload as they were unfamiliar with the role. They received their rota less than 6 weeks prior to starting and on call days had been allocated, they were told adjustments could only be made via swaps. Despite the challenges, the rota coordinator was described as responsive to emails and generally approved swap requests.

ST/Core: RDIT's described the management of the switch of rota as having a noticeable impact on their wellbeing, particularly amongst those directly affected who are no longer in the department (1 RDIT has now left and another on long term sick). Training opportunities (especially around index cases) have reduced and despite raising concerns via a variety of channels, concern remains regarding the perceived poor handling of the situation. ST's themselves created a new rota, which they consider the best available compromise under the circumstances. Despite efforts to engage with management, including through the "WeCare" process, staff were informed by management that a return to the 24-hour rota would not be considered

2.14 Handover (R1.14)

Trainers: Trainers stated that handover arrangements were robust and provided safe care for patients. Handover is used as a learning opportunity to discuss interesting cases and provide feedback.

FY1/FY2: The handover of patients arriving on the wards from subspecialties can be poorly communicated to the FY doctors. The FY to FY 8pm handover is frequently interrupted by nursing staff with non-urgent requests.

ST: RDIT's reported that handover is structured and provides safe continuity of care.

2.15 Educational Resources (R1.19)

Trainers: Not asked due to time constraints

FY1/FY2: Hot desks are available for staff to book however, access can be challenging at times due to high demand across the hospital.

ST's: Concern was raised regarding the lack of available space for staff to carry out administrative tasks, take rest breaks, or eat lunch. ST's acknowledged that 3 rooms are available for booking rest breaks, it was noted that these rooms are shared across the entire children's hospital, limiting accessibility. Additionally, although simulation kits are available, the perceived lack of dedicated space was identified as a barrier to their use.

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

Trainers: Not asked due to time constraints

FY1/FY/Core/ST: RDIT's would raise any concerns regarding their training with their educational supervisor or TPD. Most were unaware of any local trainee forums.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked due to time constraints

FY1/FY2/Core/ST: All were aware of how to raise concerns and who to contact to do so.

2.19 Patient safety (R1.2)

Trainers: Trainers felt that the environment was safe for patients both in and OOH. Ward areas are secure, and emergency procedures are supported by clear staffing structure and established protocols. Staff safety and satisfaction with the working environment have improved. However, concerns remain regarding the availability of rest facilities. Only three rooms are available for booking, shared across the hospital, and rest areas at RIE are difficult to access. Catering options OOH are limited, though new facilities on the 4th floor have been introduced. Negotiations with the management team to improve rest and catering facilities have had little progress.

During a period of rota transition, the department experienced understaffing, particularly at the registrar level. RDIT's were reluctant to take on locum shifts due to strained relationships with management, resulting in an unsafe patient-to-doctor ratio. Consultants were required to cover registrar and FY roles, leading to significant stress. Although the situation has improved, concerns remain about reluctance to pay RDIT's locum rates unless annual leave is taken before and after shifts.

FY1/FY2: There are no immediate safety concerns, although some subspecialty patients, particularly in Plastic and ENT, are not reviewed daily by the team. Spinal and Orthopaedic patients are seen regularly with clear plans in place. Whilst not unsafe, complex cases have been delayed. There are handover and nurse led safety briefings daily.

ST's: No concerns. Patient Safety or adverse events are reviewed and discussed during Datix and Morbidity and Mortality meetings.

2.20 Adverse incidents & Duty of Candour (R1.3 & R1.4) Not asked

2.21 Other

Parking remains a challenge. On-call registrars have access to parking near the hospital but the junior tier doctors do not have parking privileges and share permits among themselves. OOH access

can be difficult, especially in darker conditions, and staff are encouraged to seek security escort when needed.

3. Summary

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

Positive aspects of the visit:

- Engaged and committed trainers who are supportive of all grades of resident doctors
- Excellent clear and accessible clinical supervision for general paediatric surgery
- Patient safety is given high priority
- Valuable feedback around cases and ad hoc teaching
- All grades reported supportive clinical supervision helping them to achieve curricular competences
- All described a “great” department to work in rating clinical experience and the support received from trainers very highly

Less positive aspects of the visit:

- Challenging interactions between RDIT’s and management around rota changes and gap management
- FY departmental induction poorly attended. More structure required and to ensure mechanism in place to provide catch up for those unable to attend.
- FY difficulties around handover and clinical support for patients admitted from some surgical subspecialties, ENT, Plastics etc
- ST teaching model has been difficult to attend, impacted by rota and the day it occurs. An alternative model could be explored
- FY significant delay in issuing badges which had significant impact on ability to do their role. At the feedback meeting this was reported as a one-off event and should not recur.
- Lack of facilities to support working environment around catering, rest and available space.

4. Areas of Good Practice

Ref	Item	Action
4.1	Supportive and dedicated trainers who actively contribute to the development of resident doctors at all levels	
4.2	There was good and valuable clinical experience at all grades	

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	Teaching	The department should review teaching schedule and structure to maximise attendance for RDIT's
5.2	Facilities	Review the arrangements for rest facilities and room booking system during OOH shifts (ST)

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	A process must be put in place to ensure that any trainee who misses their induction session is identified and provided with an induction. Induction to cover subspecialty patient management.	April 2026	FY
6.2	The current ST rota must be reviewed to ensure provision of learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme	April 2026	ST

	including daytime specialty training, attendance at clinics &/or theatre sessions and ability to access index cases.		
6.3	Trainees must be provided with clearly identified seniors who are providing them with support for all clinical areas they cover (This specifically relates to subspecialty patient admissions).	April 2026	FY