Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	20th November 2025	Level(s)	FY and ST
Type of visit	Triggered	**Hospital**	Royal Infirmary of Edinburgh
Specialty(s)	Neurosurgery	**Board**	NHS Lothian

Visit panel	
Mr Brian Stewart	Visit Chair - Associate Postgraduate Dean – Quality
Dr Reem Al Soufi	Associate Postgraduate Dean – Quality
Dr Hazel Halbert	Training Programme Director
Dr Michaela Watt	Resident Doctor in Training Associate
Mrs Natalie Bain	Quality Improvement Manager
Mr David Soden	Lay Representative
In attendance	
Mrs Susan Muir	Quality Improvement Administrator

Specialty Group Information		
Specialty Group	Medicine, Surgery, Anaesthetics, ICM & Emergency Medicine	
Lead Dean/Director	Dr Adam Hill	
Quality Lead(s)	Dr Reem Al Soufi Dr Fiona Drimmie Ms Kerry Haddow Dr Alan McKenzie	
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Miss Vhari MacDonald	
Unit/Site Information		
Non-medical staff in attendance		
Trainers in attendance	7 trainers	
RDIT's in attendance	6 ST, 4 FY's	

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

Date report approved by Lead Visitor	2nd December 2025

1.   Principal issues arising from pre-visit review:

Following review and triangulation of available data, including the GMC National Training Survey and NES Scottish Trainee Survey, a Deanery visit is being arranged to Neurosurgery at Royal Infirmary of Edinburgh. The following Data Review Panel requested this visit: Medicine, Surgery, Occupational Medicine & AICEM around the following concerns:

NTS 2025 Data:

All trainee:

Red Flags: Facilities, Induction, Local Teaching, Reporting Systems, Rota Design and Supportive Environment

Pink Flags: Educational Supervision and Handover

F2 Surgery:

Red Flags: Clinical Supervision, Educational Supervision, Facilities, Reporting Systems and Rota Design

Pink Flags: Educational Governance, Feedback, Overall Satisfaction and Teamwork

ST:

Red Flags: Educational Governance, Facilities, Induction, Local Teaching, Overall Satisfaction Regional Teaching, Rota Design and Supportive Environment

Pink Flags: Feedback, Handover and Reporting Systems.

STS Jun 2025 Data:

All trainee:

Red Flags: Educational Environment & Teaching, Equality and Inclusivity and Induction

Foundation Neurosurgery:

Red Flags: Educational Environment & Teaching and Induction

ST:

Red Flags: Educational Environment & Teaching and Wellbeing Support

We received additional information from the JCST which highlighted a significant change on the background of the NTS / STS data this year, which has brought some urgency around this visit taking place and the reason we initiated a triggered visit for the site.

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 Mr Imran Liaquat for his 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 as highlighted by the NTS survey results. We would also like to thank Mr Mark White for forwarding on his presentation relating to Foundation Years training in the department.

2.1   Induction (R1.13):

Trainers: The trainers report that a comprehensive induction is provided for Foundation resident doctors in training (RDIT's), including presentations from departmental and site staff, a tour of the department and staff room, and set-up of ID, IT access, and TRAK. The same induction applies to new Specialty RDIT's (STs), with ST1s receiving an induction pack on changeover day, followed by a tour, introductions to trainers, and IT/theatre access, enabling them to be ready to begin in post. A buddy system supports new STs during their first week, although recent staffing challenges have affected its implementation. RDIT's who miss the scheduled induction receive a personalised session with a trainer, and all trainees are provided with online induction materials via email.

FY RDIT's: All those who were able to attend the daytime induction to post did so and felt the induction process was well established and useful. For those who were post nights received a catchup induction. The induction prepared the FY's for beginning in post and appropriate escalation policies were discussed at induction. It was noted that the FY1 had a good shadowing period beforehand.

ST RDIT's: All ST RDIT's reported having an induction when beginning in post, however, for some that was a few years ago and it is not necessary to repeat it. Those who were new in post in August 2025, noted that induction was satisfactory and prepared them for beginning in post.

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

Trainers: The trainers highlighted in their departmental presentation that there are various teaching opportunities within the department. There is a Friday afternoon session for RDIT's to attend and these sessions are morbidity and mortality meetings (M&M) combined with cased based discussion about complex spinal cases/cranial cases as well as external talks from researchers/industry people. A further local session has recently started on a Wednesday; however, it is new and will require a consultant to have this integrated into their job plan to undertake the role. The trainers noted that although RDIT's are encouraged to attend both local and regional teaching, the staffing levels have impacted their ability to attend. It was highlighted that there have been incidents of RDIT's being unable to attend teaching in order to ensure a safe minimum of staffing levels. The trainers comment that local teaching is specifically aimed at ST3 RDIT's and above, although the FY's and ST1-2 are welcome to attend. The FY's attend a weekly teaching session with Mr Kaliaperumal, that includes wellness and mindfulness whilst also providing a supportive role for career guidance. It's also highlighted that the clinical fellow will hold the bleep weekly to enable maximum teaching attendance where possible.

FY RDIT's: The FY's report that the local teaching is currently organised by clinical fellows, with a one-hour session held every Friday afternoon. In addition, ad hoc teaching sessions take place on the ward every other Wednesday, and they are encouraged to attend these. It is emphasised that attendance at teaching is generally not affected by clinical work. The FY's state that they are able to attend the majority of their scheduled teaching sessions for both FY1 and FY2 programmes.

ST RDIT's: The ST's report that they currently attend less than one hour of teaching per week. There is a Friday afternoon educational meeting, which can be joint session with another specialty and follows a rolling weekly programme, but it is not dedicated teaching. These sessions are delivered by RDIT's, and attendance is often affected by short staffing. A new RDIT-led teaching programme with consultant support was introduced recently. Previously, Wednesday teaching was protected, but this is no longer the case. Some RDIT's have missed regional teaching due to staffing shortages and workload, with sessions that were due to be held in Royal Infirmary Edinburgh (RIE) being cancelled as there was no capacity for RDIT's to host the presentations. It is noted that there has been ongoing discussion about balancing teaching attendance with service safety, leading to an agreement that three trainees remain on site while two attend. Consultants initially supported attendance via Teams,

but engagement has declined, with the last regional teaching session attended in March. Overall, attendance and delivery vary significantly depending on availability.

2.3   Study Leave (R3.12)

Trainers: Not formally asked, no concerns raised in survey data or PVQ.

All RDIT's: Not formally asked and no concerns raised.

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

Trainers: The Training Programme Director (TPD) initially allocated trainees in 2021, but the structure has since evolved. Currently, there are three Clinical Supervisors (CS), each overseeing two trainees for either one or two years, while Educational Supervisors (ES) are assigned for three years before rotation. The trainer role extends beyond formal supervision and includes a pastoral element; however, clarity around funded sessions and job plan allocations remains unclear. Many trainers report going above and beyond their allocated time, with some fulfilling educational responsibilities despite having no dedicated time in their job plan. Opportunities to expand the trainer pool are constrained by availability. Roles and expectations are discussed during annual reviews, and regular consultant meetings provide a forum to raise RDIT-related concerns, sometimes as formal agenda items. Both formal and informal routes exist for addressing issues as they arise.

FY RDIT's: All FY's have an allocated ES and have met with them both formally and informally on a regular basis. Most answered that they have had their start and end of block meetings. They highlight that their ES's are approachable and supportive.

ST RDIT's: The ST's report that they meet with their ES informally on a regular basis and it can be variable when they meet them in an official capacity. The RDIT's were informed by the TPD as to who was their allocated ES and all reported that they have agreed their educational objectives. It was highlighted that when new RDIT's are beginning in post that they are paired with a Neurosurgery registrar when doing their OOH shifts and this was highly commended.

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 they do not use the term SHO in the department but do often find that the RDIT's refer to themselves as this term. The department do not have colour coded badges but they do have a picture board, but admittedly it is not always up to date as the FY RDIT's rotate often. At induction, FY1 and FY2's receive a contact list and clear escalation policies, with registrars conducting ward rounds and remaining easily accessible. Registrars understand escalation procedures and are comfortable contacting the on-call consultant, with all consultants available by telephone. There have been no reported incidents of FY's working beyond their competence during daytime hours, although out of hours (OOH) may present challenges, emphasising the need for awareness of escalation routes. For ST RDIT's, referral pathways have led to patients being admitted to the neurosurgical unit who would not typically be accepted elsewhere. Despite trainees having alternative management plans, they often feel pressured to accept inappropriate admissions, creating significant strain. Trainers report difficulty managing these cases, which they attribute to a Lothian-centric, pathway-driven approach that prioritises process over patient-centred care. This situation impacts RDIT's educational experience, as time spent managing unsuitable patients reduces opportunities for core neurosurgical training.

FY RDIT's: The FY's report that they are aware of the appropriate contacts both during the day and out of hours. During the day, they would contact the ward registrar, and after 5pm, the OOH registrar. While there can be some contention at changeover, communication is generally reasonable and registrars are receptive after this period. The F1 role is supernumerary but note that they are always able to escalate concerns to someone. F2s report that when patients deteriorate quickly, support is readily available from colleagues.

ST RDIT's: The RDIT's report that they are always aware of who to contact both during working hours and OOH. However, some report managing problems beyond their competence, which tends to occur during staff shortages when they need to seek consultant support. Consultants are not always receptive of this, but patient safety is maintained as RDIT's can escalate appropriately when required. Overall, the RDIT's described the consultants as approachable and supportive.

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

Trainers: The trainers all report that they are aware of Intercollegiate Surgical Curriculum Programme (ISCP), surgical portfolio and are competent with the curriculum requirements. As highlighted in the presentation, the RDIT's are meetings their operative targets, with some RDIT's being able to achieve an early Certificate of Completion of Training (CCT). The trainers have regular logbook reviews and believe they give fair outcomes to allow for more direct training to be given. The trainers state that teaching attendance targets can be difficult to achieve, but they hope with the new teaching sessions that have been implemented that this will improve. It emphasised that the referral pathways in the hospital impact the amount of time spent doing tasks that are of little educational benefit.

FY RDIT's: The FY's report that around 20% of tasks are considered to have limited educational benefit, but they highlight that they will spend more time reviewing patients. It's stated that attendance at clinics or theatre is not formally built into the rota; however, FY2s cover the pre-assessment clinic a few times during the rotation. On Thursdays, during two development blocks, some trainees have the opportunity to attend clinics or theatre, and others have done so on an ad hoc basis. Registrars are keen for foundation doctors to attend theatre, but this can depend on ward workload.

ST RDIT's: The ST's report that there are generally no concerns about achieving overall competence, although some elements can be missed due to ward rounds and service demands. Logbook case numbers are satisfactory, but obtaining index cases can be challenging, and emergency operations tend to be less complex compared to elective cases. The RDIT's note that approximately 50% of their time is spent on duties that offer little or no educational value. Clinics usually take place in the mornings, but attendance alongside other commitments is difficult.

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

Trainers: As demonstrated in the presentation the RDIT's are meeting their operative targets and completing assessments regularly. The trainers note that there is no official opportunity to benchmark assessments, but there are times at the Friday consultant meeting where there is the opportunity to discuss trainee progression.

FY RDIT's: Most FY's report that is can be difficult to complete some curriculum assessments such as mini-CEXs and case-based discussions (CBD) during their post. However, they do report that they are able to get them completed when doing OOH shifts. FY1's report that they find it reasonable to complete their assessments.

ST RDIT's: All ST's report that they find it easy enough to complete WPBA's and they are fair and consistent when completed.

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

Trainers: Not formally asked, no concerns raised in the survey date or PVQ.

All RDIT's: Not formally asked, no concerns raised in the survey date or PVQ.

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

Trainers: Not formally asked, no concerns raised in the survey date or PVQ.

All RDIT's: Not formally asked, no concerns raised in the survey date or PVQ.

2.10   Feedback to RDIT's (R1.15, 3.13)

Trainers: The trainers report that there are both formal and informal methods for providing feedback to trainees on their decisions. Trainers may give feedback verbally or via email and encourage reflective practice, particularly when issues arise. Meetings between trainers and trainees are common, and any information from DATIX is managed formally. A morning meeting summarises key points and offers an excellent opportunity to discuss management plans, although FYs can rarely attend due to rota demands. Feedback is continuous and, for FYs, is often received through meetings with supervisors, nursing staff, and through Team Assessment of Behaviour (TABs).

FY RDIT's: The FYs report that formal feedback on clinical decisions is limited during the day as the majority of their interactions are more about discussing plans rather than receiving structured feedback. At night, trainees often work one-to-one with the on-call registrar, which provides more

opportunity for informal feedback. The FY's highlight that they can gain feedback by approaching registrars directly. FY1's will typically receive feedback indirectly by discussing cases with FY2 colleagues.

ST RDIT's: The RDIT's report that they are able obtain feedback fairly easy and they are able to approach a consultant to get feedback on their decisions. It's stated that the consultant will either follow-up via email or review the patients themselves, then will give the RDIT's feedback on their management plan. Most RDIT's note that they receive timely feedback and will receive it, however there is the odd occurrence when a consultant is on leave, but they can get feedback from the on-call consultant. The ST's all highlight that they also feedback to the FY's when required.

2.11   Feedback from RDIT's (R1.5, 2.3)

Trainers: The trainers highlight that the FY supervisor is readily available and approachable to allow for feedback to be given. Mr White regularly talks with the FY's to ensure that they are coping especially, post weekend shifts. It's noted that there is no formal "rate the trainer" feedback mechanisms. However, the RDIT's can attend the departmental meeting on a Friday to raise any concerns they may have and they will be addressed appropriately.

FY RDIT's: The FY's report that they complete feedback forms following teaching sessions. They note that in order to provide feedback on other aspects, they would need to approach supervisors directly. There is no awareness of any formal RDIT forums, so most feedback and discussion occurs informally by talking to their colleagues.

ST RDIT's: The ST's report there are no formal avenue to raise concerns, however, they are able to informally raise concerns to TPD, Clinical Directors and service managers. It is noted that there is a SAC rep on an annual panel for Scotland at Annual Review of Competence (ARCP) time where they can engage with educational teams. It was also highlighted that there are specialty chief registrars within the hospital but they do not utilise them.

2.12   Culture & undermining (R3.3)

Trainers: The trainers report that at the start of induction, RDIT's are informed about escalation processes and provided with consultant contact numbers for any issues. The importance of addressing undermining and bullying behaviours, a significant theme in surgery highlighted by all the Surgical Colleges is emphasised throughout induction and discussed regularly at consultant meetings. No concerns have been reported, but supervisors ensure RDIT's understand the escalation pathway: issues can be raised with the ES or CS, and if the concern involves a supervisor, RDIT's may escalate to the ADME. The team-based structure and availability of consultants make them approachable, and trainees are encouraged to provide feedback and escalate concerns when necessary.

FY RDIT's: The FY's report that the department is very supportive, with registrars consistently accommodating and helpful when they have concerns about patients. Overall, colleagues are considered friendly and approachable. The RDIT's note that they feel that they would be able to raise concerns with their supervisors and believe that they would be acted upon appropriately.

ST RDIT's: The ST's report that there are ongoing hospital-wide issues, and the relationship between the Emergency Medicine department (ED) and Neurosurgery can be strained. Despite being raised at a higher level, no resolution has been achieved. The RDIT's also highlight that at times they are experiencing passive-aggressive comments from the ED staff when attending to review patients.

2.13   Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The trainers highlight that the rota designed to incorporate scheduled theatre time, while RDIT's retain autonomy over clinic attendance. A fortnightly rota is published and it is relevant to individual training needs. It's stated that recently RDIT's were removed from fracture clinics, which has reduced attendance; ST3 and above have been reminded of the need to attend clinics to meet curriculum requirements. Staffing challenges as detailed in the presentation highlighted that Specialty doctors only need to give one month's notice, and LTFT arrangements further impact numbers. The department works to mitigate these issues, but gaps in the rota remain difficult to manage, sometimes leaving ST2s covering overnight shifts. In certain cases, filling these gaps can be unsafe, and internal cover places additional strain on RDIT's well-being.

FY RDIT's: The FY's report that at the beginning of the post there were no staffing gaps, but as the post went on there were gaps and the department has filled these with locums. While trainees can attend M&M and MDT meetings, ward pressures often make this difficult. There are opportunities to attend rehab meetings or neurosurgery/radiology sessions, which are encouraged at induction, however in reality, they are difficult to get to due to are limited due to ward work. On a positive note, the FY's do have opportunities to undertake QI projects, with registrars actively suggesting ways to get involved.

ST RDIT's: The RDIT's report that there are currently gaps in the rota that were previously filled by locums, but there are now restrictions in bringing in external locums to fill these gaps. Therefore, these gaps are now expected to be covered by registrars. The rota has reduced from 12 to 10, creating additional pressure. It does not accommodate specific learning opportunities, as there are insufficient staff to balance service provision with curriculum requirements. As a result, the RDIT's often need to plan well in advance to secure educational experiences.

2.14 Handover (R1.14)

Trainers: The trainers report that there is a robust formal handover to which the ST's attend and review all patients. There is also a CEPOD meeting prior to theatre. The FY's will attend the Hospital at Night (HAN) meeting and they are encouraged to attend the 8am meeting to handover tasks.

FY RDIT's: Not formally asked, however no concerns were raised in the PVQ.

ST RDIT's: The panel were unable to explore this in depth due to time constraints; however, it was noted that handover is very much a business handover that is robust but leaves limited opportunity to ask questions and learn from it.

2.15 Educational Resources (R1.19)

Trainers: Not formally asked, no concerns raised in the survey date or PVQ.

All RDIT's: Not formally asked, no concerns raised in the survey date or PVQ.

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.

All RDIT's: Not formally 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 formally asked, however, the site presentation detailed the educational governance process and how these have allowed progression of RDIT's throughout their training programme. It was also highlighted in the presentation, how RDIT's can escalate concerns with the senior management team.

FY RDIT's: The FY's reported that they would be able to escalate any concerns to their supervisor relating to teaching and feel that it would be actioned appropriately.

ST RDIT's: Not formally asked.

2.18   Raising concerns (R1.1, 2.7)

Trainers: The trainers report that the RDIT's are well supported by consultants, nurses, and ANPs, to raise any concerns that they may have. RDIT's can raise concerns formally through a Datix submission or directly with their Educational or Clinical Supervisor. Additional escalation routes include the Clinical Director or senior management, providing multiple pathways for addressing issues.

FY RDIT's: The FY's report that they would initially raise concerns with the registrar, who can escalate issues to the consultant when necessary. They also have the option to raise concerns directly with the consultant. ANPs are present on the ward, knowledgeable about pathways, and able to guide the FY's appropriately.

ST RDIT's: The ST's report that is it very rare that they would feel the need to escalate any patient safety concerns. It was noted that there was an occasion recently and it was escalated to the TPD and was addressed efficiently. As previously noted, ST are aware of escalation pathways and would be confident in using them.

2.19   Patient safety (R1.2)

Trainers: Not formally asked.

FY RDIT's: All FY's reported that they would be happy if a family member were admitted to the unit and they believe their quality of care would be satisfactory.

ST RDIT's: As above, there RDIT's do not have many experiences with patient safety concerns, but the ST's would be able to escalate when required and be supported when doing so.

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

Trainers: The trainers report that adverse incidents are reported via DATX. There is a monthly M&M meeting to discuss these.

All RDIT's: Not formally asked in session, however from the PVQ, all RDIT's indicated that they use DATIX to submit adverse incidents and they are discussed at the monthly M&M meetings.

2.21   Other

3.   Summary

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

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Positive aspects of the visit:

- Throughout the visit, the panel observed that the department comprises a supportive group of RDIT's alongside a cohesive team of consultants, all of whom are managing significant workload and staffing challenges.

- The panel was pleased to note a strong emphasis on training, which is consistently reinforced by the RDITs. This demonstrates the presence of engaged and motivated trainers.

- The panel thought that the buddy system was good approach to training and the department should praised for its success.

- It was heard by various RDIT's that the Consultants are approachable and supportive.

- The panel was pleased to learn that, despite workload and staffing challenges, the RDITs successfully completed WPBAs and met curriculum requirements.

Less positive aspects of the visit:

- Current staffing levels are considered insufficient to prioritise education over service delivery, with educational opportunities being constrained by the need to complete service-related tasks.

- Local teaching sessions remain suboptimal. Despite efforts to enhance provision, opportunities to attend teaching are still limited.

- It was highlighted to the panel that access to regional teaching is variable, due to not going ahead or RDIT's are unable to attend. The panel feel that it would be valuable if the Training Programme Director reviews this with the RDIT's.

- While educational supervision is incorporated into some job plans, both its presence and the time allocated for delivery remain inconsistent.

- Referral pathways have become increasingly restrictive, creating tensions between the Emergency Department and Neurosurgery and resulting in episodes of incivility.

- Rota gaps were identified as a concern, as internal cover arrangements have resulted in an increased workload for the RDITs.

4. Areas of Good Practice

Ref	Item	Action
4.1	There is a strong focus on training in the department and this is to be commended.	
4.2	There is a cohesive and supportive group of trainers and resident doctors.	
4.3	The buddy system that the department have created is an excellent support for those new in post.	

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	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Trainee cohorts in scope
6.1	Ensure that service needs do not prevent trainees from attending clinics and other scheduled learning opportunities	20th August 2026	All RDIT's
6.2	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.	20th August 2026	All RDIT's
6.3	A programme of formal teaching that is appropriate to the curriculum requirements of trainees should be maintained.	20th August 2026	All RDIT's

6.4	All Consultants, who are trainers, must have time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	20th August 2026	Trainers
6.5	The department must have a clear process for supporting RDIT's who have been undermined from staff out with the department. The RDIT's should be provided with feedback on actions taken to address this.	20th August 2026	All RDIT's
6.6	Alternatives to doctors in training must be explored and employed to address the gaps in the rota that are impacting on training.	20th August 2026	All RDIT's