

Scotland Deanery Quality Management Visit Report



Date of visit	27 th November 2025	Level(s)	Foundation & Specialty
Type of visit	Immediate Triggered (virtual)	Hospital	Aberdeen Royal Infirmary
Specialty(s)	Trauma & Orthopaedics	Board	NHS Grampian

Visit Panel	
Dr Fiona Drimmie	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Fiona Cameron	Foundation School Director
Dr Hazel Halbert	Training Programme Director
Dr Eleanor Dow	Trainee Representative
Mr Eddie Kelly	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine, Surgery, Occupational Medicine & AICEM
Lead Dean/Director	Professor Adam Hill
Deputy Dean/Director	Dr Alastair Murray
Associate Postgraduate Deans	Dr Reem Al-Soufi, Dr Fiona Drimmie, Dr Kerry Haddow & Dr Alan McKenzie
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Ms Vhari Macdonald
Unit/Site Information	
Trainers in attendance	0
Resident Doctors in attendance	11 (4-F1, 3-F2, 4-ST)

Feedback session:	Chief	0	DME	1	ADME	1	Medical	0	Other	12
Managers in attendance	Executive						Director			

Report approved by: Dr Fiona Drimmie (Visit Lead)
 Professor Adam Hill (Lead Dean Director)
 Professor Lindsay Donaldson (Deputy Medical Director & Quality Lead)

1. Principal issues arising from pre-visit review:

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.

Serious concerns have been raised regarding patient safety and the wellbeing of resident doctors in training within Trauma & Orthopaedics in particular HDU at Aberdeen Royal Infirmary therefore a Deanery Immediate Triggered Visit has been scheduled.

NTS Survey Data (2025):

NTS TREND 2020-2025		Outcome					
Programme Group	Indicator	2021	2022	2023	2024	2025	
All Trainees Trauma and orthopaedic surgery	Adequate Experience	75.89	82.5	75	73.96	66.67	
	Clinical Supervision	90.77	86	90	86.35	76.5	
	Clinical Supervision out of hours	91.35	83.75	83.33	82.29	76.14	
	Educational Governance	77.38	75	70	65.97	63.89	
	Educational Supervision	83.93	81.25	81.25	78.65	74.48	
	Facilities	58.98	57	62.5	67.86	59.58	
	Feedback	79.81	70.83	88.54	75.38	61.94	
	Handover	74.83	68.75	81.77	87.5	77.5	
	Induction	86.16	77	77.5	79.79	73.65	
	Local Teaching	75	80	53.75	60.24	72.67	
	Overall Satisfaction	79.29	68	70	72.5	59.17	
	Regional Teaching	68.06	65.28	59.38	47.02	67.5	
	Reporting Systems	78.57	75	77.5	78.33	77.5	
	Rota Design	63.39	57.5	42.71	52.6	35.42	
	Study Leave	80.42	77.08	74.48	85.71	47.5	
	Supportive environment	68.57	68	65.83	77.5	64.17	
	Teamwork	69.64	56.67	77.78	83.33	69.44	
	Workload	46.28	35	19.45	28.65	27.08	
	Number of responses		14	5	6	12	12
	F1	Adequate Experience	73.44	77.5	78.95	73.91	61.18

Surgery F1	Clinical Supervision	76.67	81.75	86.38	80.97	72.35
	Clinical Supervision out of hours	74.03	80.7	80.26	79.71	74.88
	Educational Governance	66.67	60.42	72.69	61.74	55.09
	Educational Supervision	73.44	77.81	83.88	80.16	72.04
	Facilities	45.63	57.23	59.5	52.5	59.58
	Feedback	27.08	64.91	68.61	73.04	64.77
	Handover					
	Induction	61.88	75	80.53	83.81	72.37
	Local Teaching					
	Overall Satisfaction	64.69	73.5	73.95	72.83	53.42
	Regional Teaching					
	Reporting Systems	66.54	68.16	75	70.95	66.15
	Rota Design	34.17	40.31	52.43	47.16	33.88
	Study Leave					
	Supportive environment	54.06	65	65.26	66.96	60.53
	Teamwork	63.02	73.68	76.97	74.24	71.49
	Workload	39.58	36.98	38.27	33.15	34.54
	Number of responses	16	20	19	6	18
	ST Trauma and orthopaedic surgery	Adequate Experience	79.17	91.67	75	83.93
Clinical Supervision		96.82	98.33	96.25	93.57	91
Clinical Supervision out of hours		97.16	97.92	95.31	90.18	88.75
Educational Governance		79.86	97.22	68.75	80.95	81.67
Educational Supervision		90.1	100	81.25	86.61	88.75
Facilities		58.88	70	62.5	71	51.67
Feedback		92.42	94.44	84.72	89.29	73.44
Handover		74.83	68.75	81.77	87.5	77.5
Induction		89.69	86.67	82.5	76.79	86.5
Local Teaching		75	80	53.75	60.24	72.67
Overall Satisfaction		86.25	88.33	81.25	80	78
Regional Teaching		68.06	65.28	59.38	47.02	67.5
Reporting Systems		80.83	83.33	80	82.86	81
Rota Design		72.92	72.92	51.56	64.29	50
Study Leave		80.42	77.08	74.48	85.71	47.5
Supportive environment		74.17	76.67	75	85	71
Teamwork		73.61	52.78	81.25	86.91	70
Workload		51.04	47.92	21.36	35.71	18.75
Number of responses		12	3	4	6	5

STS Survey Data (2025):

Bottom 2%.

STS TREND 2021-2025

Programme/Level group	Indicator	2021	2022	2023	2024	Jan 2025	Jun 2025
All Trainees Trauma and Orthopaedic Surgery	Clinical Supervision	white	red	white	white	red	red
	Discrimination	yellow	yellow	white	white	pink	red
	Educational Environment & Teaching	yellow	yellow	white	white	red	red
	Equality & Inclusivity	yellow	yellow	white	white	white	red
	Handover	white	red	pink	white	pink	red
	Induction	white	white	white	white	red	red
	Team Culture	white	white	pink	white	white	white
	Wellbeing Support	yellow	yellow	white	white	white	white
	Workload	white	red	red	white	white	white
	Catering Facilities	yellow	yellow	pink	white	white	white
	Rest Facilities	yellow	yellow	red	white	white	white
	Travel	yellow	yellow	white	white	white	white
	Number of responses	22	24	29	18	11	19
	Foundation Trauma and Orthopaedic Surgery	Clinical Supervision	red	red	white	pink	red
Discrimination		yellow	yellow	white	white	red	red
Educational Environment & Teaching		yellow	yellow	pink	white	red	red
Equality & Inclusivity		yellow	yellow	white	white	white	red
Handover		red	red	red	white	red	red
Induction		white	white	white	white	red	red
Team Culture		white	white	pink	white	white	white
Wellbeing Support		yellow	yellow	white	white	white	white
Workload		red	white	red	white	red	white
Catering Facilities		yellow	yellow	red	white	white	white
Rest Facilities		yellow	yellow	red	white	white	white
Travel		yellow	yellow	white	white	white	white
Number of responses		13	18	21	12	6	13
ST Trauma and Orthopaedic Surgery		Clinical Supervision	white	white	white	white	white
	Discrimination	yellow	yellow	white	lime	white	white

Educational Environment & Teaching	yellow	yellow	white	white	white	white
Equality & Inclusivity	yellow	yellow	white	white	white	red
Handover	white	white	white	green	white	white
Induction	white	white	white	white	white	red
Team Culture	white	white	white	white	white	white
Wellbeing Support	yellow	yellow	white	white	white	white
Workload	white	white	white	white	white	white
Catering Facilities	yellow	yellow	white	white	white	white
Rest Facilities	yellow	yellow	white	white	white	white
Travel	yellow	yellow	white	white	white	white
Number of responses	9	6	8	6	5	6

The visit follows several Quality Engagement Meetings and therefore it was agreed not to include a presentation from site or session with Trainers from the department.

The pre-visit questionnaire was completed by 3 F1s and 1 ST.

2.1 Induction (R1.13):

F1: F1s reported receiving departmental induction and a tour of the ward. In addition, they also received an induction session from former F1s which they found very useful.

F2: F2s reported receiving good induction to T&O at Woodend hospital however received no specific induction to T&O at Aberdeen Royal Infirmary (ARI). They noted that the trauma and critical care handbooks are extremely useful.

ST: STs reported receiving good induction. Comment was made on a period of shadowing given to an ST who started out of sync which was helpful and appreciated. The only issue raised was around the length of time taken to receive IT passwords which they believe has improved.

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

F1: F1s reported that there is good quality departmental teaching arranged and provided by F2s and clinical development fellows (CDFs) which they appreciate. They noted being able to attend around

20-50% of regional teaching. Non-attendance at teaching is due to a heavy out of hours (OOH) commitment, being on zero days or workload on the ward. It was suggested that alternating the days and times of departmental teaching may help with attendance. They also confirmed being invited to attend Morbidity and Mortality meetings (M&M) held in Woodend Hospital via Microsoft Teams however again find attending difficult.

F2: Not asked, no concerns raised in pre-visit questionnaire.

ST: STs reported that there is a departmental teaching programme which takes place on the last Friday of the month, and they can attend regularly. They are also able to attend around 60% of regional teaching and noted attendance can be impacted by number of on-call sessions. Priority is given to those about to undertake the exam should they have missed a session, and they provide cover to allow others to attend.

2.3 Study Leave (R3.12)

F1/F2: Not asked, no concerns raised in pre-visit questionnaire.

ST: STs reported no concerns in requesting or taking study leave.

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

F1: Within the pre-visit questionnaire F1s confirmed having a designated educational supervisor who they meet 2-3 times within the block and have set educational objectives for the post.

F2: F2s confirmed having a designated educational supervisor who they meet twice within the block and have set educational objectives for the post. They noted regularly interacting with consultants on the ward and in theatre.

ST: Not asked, no concerns raised in pre-visit questionnaire.

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)

F1: F1s reported that during the day patients come under different teams and therefore should they require support their first point of contact is the ST for that team which can be problematic should they be in theatre or the Emergency Medicine department. Seniors are very nice and approachable, and should urgent supervision be required they believe someone would come to support them. There are also mobile numbers that can be used to contact for advice. F2s and advanced nurse practitioners (ANPs) also provide useful support and direction during the day. OOH the 2 main points of contact are the T&O registrar and medical registrar. The T&O registrar is generally extremely busy and there can be some delay in receiving support however they find contacting the medical registrar or critical care team easier. They reported regularly having to deal with problems beyond their competence and noted significant concerns regarding the high dependency unit (HDU). Patients in HDU are unwell and can have complex issues, F1s are often the first point of contact for these patients and can spend a significant amount of time with one patient where they are expected to make clinical decisions and changes to drugs such as vasopressors. They consider this to be a risk to patient safety. They regularly manage these patients without direct supervision for significant periods and are having conversations with family members regarding end-of-life care often without direct senior input. These issues have been raised with consultants who have escalated to the management team within the hospital. Since escalating June 2025 no changes have been recognised as taking place.

F2: F2s reported clear escalation pathways to the on-call registrar OOH. They noted that escalation during the day can be challenging due to the STs working within teams and it is not always clear who is responsible for the patients or who should be contacted should that ST be on annual leave. When seeking support, they often struggle to get advice and have received comments such as 'that's not my patient'. They believe they must cope with problems out with their level of competence in particular relating to calls from HDU seeking registrar support which they believe an FY should not be expected to manage. Medical specialties provide good support as do the critical care team overnight. They noted challenges with the accessibility of seniors however consider them to be friendly and approachable.

ST: STs report no concerns with supervision. They confirmed that they are aware of who to contact during the day and OOH and do not feel they have had to cope with issues out with their level of competence. They noted that supervisors provide excellent support and are accessible and approachable.

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

F1: F1s reported that the post has allowed them to develop skills and competence in managing acutely unwell patients. They believe that a high percentage of their working day is spent carrying out tasks of little or no benefit to their education or training.

F2: F2s reported difficulties in obtaining supervised learning events (SLEs) as they have little interaction with seniors on the wards. They believe they have developed skills and competencies in managing the acutely unwell patient through necessity and noted a significant amount of time spent carrying out tasks of little or no benefit to their education or training. They commented that there is little organisation when discharging patients, there is no preparation in sending request to pharmacy and often discharge paperwork is not up to date as the heavy workload prevents this forward planning.

ST: STs reported that ARI T&O are currently absorbing the workload redirected from Dr Gray's with no additional resource. Changes have been made to the rota to include a backshift in an aim to help improve the dayshift however these changes have also changed on-call commitment and are having a knock-on effect to elements of training and exposure to elective work. Priority is to ensure trauma is appropriately staffed. They explained that they are allocated to sub-specialty blocks e.g. shoulder, spine etc, throughout the training year where they are required to meet specific competence. Due to the increased workload and changes to the rotas it can be difficult to meet those requirements as there are no opportunities to make up missed clinics or elective work should they be on the rota for a trauma week. They commented that 80% of their time is now spent covering trauma at ARI. Most are coming into work on days off to try to reach minimum requirements and prevent an extension to training at their annual review of competence progression panel (ARCP). This is impacting morale and wellbeing.

They believe the post does allow them to develop skills and competence in managing the acutely unwell patient. They reported that much of their time is spent undertaking tasks of little benefit to their education or training. In order to manage patient flow, each ST is responsible for the follow up and recall of trauma cases for the next step in their management. This can include phoning patients with appointments etc. This work is mainly administrative and could be carried out by a trauma coordinator role. They echoed concerns raised by FYs regarding HDU and feel they are expected to look after patients out with their level of competence in particular when asked to change doses of metaraminol.

They often come in early to see review these patients prior to starting shift at 8am however can still be inundated with later calls regarding these patients' querying decisions and requesting patients are reviewed again. There is a perceived lack of trust in the STs abilities.

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

F1: F1s reported no difficulties in obtaining workplace-based assessments. STs are approachable and very happy to complete assessments.

F2: F2s reported difficulties in obtaining workplace-based assessments as there is little direct supervision to allow assessments to be requested. There are more opportunities OOH as you have access to medical registrars who are happy to review patients and give direct feedback.

ST: STs reported no difficulties in obtaining workplace-based assessments.

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

F1/F2/ST: Not asked, no concerns raised in pre-visit questionnaire.

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

F1/ST: RDITs reported that there are no regular quality improvement meetings and have little opportunity to undertake or get involved with a project. STs commented that undertaking a project in trauma would be impossible with the current workload and staffing, they have no dedicated protected educational time.

F2: Not asked, no concerns raised in pre-visit questionnaire.

2.10 Feedback to resident doctors (R1.15, 3.13)

F1: F1s noted receiving on the spot feedback from seniors when they escalate a patient, they go through the management plan, discuss and agree any changes. Feedback is positive and there is no blame culture in the department.

F2: F2s reported receiving no feedback on the management of patients to allow learning and development. They noted providing some feedback to F1s.

ST: STs reported receiving regular feedback which is constructive and meaningful.

2.11 Feedback from resident doctors (R1.5, 2.3)

F1/F2: FYs are unaware of any formal opportunities to provide feedback to trainers or the management team on the quality of their training. F1s noted a meeting being held with a CDF to discuss improvements that could be made however are unaware of the output from this meeting. F2s commented they could give feedback at their end of block meeting.

ST: STs reported that they can provide feedback on their training via the surveys or the chief resident. They noted being encouraged to take any issues to the chief resident to take forward at senior staff meetings.

2.12 Culture & undermining (R3.3)

F1/ST: F1s reported no concerns related to team culture or bullying and undermining within the department. All staff are supportive and approachable.

F2: Not asked, no concerns raised in pre-visit questionnaire.

2.13 Workload/Rota (R1.7, 1.12, 2.19)

F1: F1s believe that any gaps within the rota have been filled with locums. They reported a high level of OOH around 60% which can compromise wellbeing if there is short notice sick leave which then leaves only one F1 on shift overnight. They noted good support from the rota co-ordinator who works hard to ensure suitable cover is requested for short notice short term sick leave however difficulties arise when they finish work and reports come in after 4pm as there is no one to manage this and put out a request for cover. They recognise efforts made to improve the rota from previous F1 feedback and believe the team are doing their best to provide a good training experience.

F2: F2s reported no issues with the rota. They explained that their main base is Woodend hospital and they rotate out to ARI covering Monday – Friday, 9am – 5pm.

ST: STs confirmed that there is one gap within the rota which has been advertised and picked up by a locum. They noted that it is easier for them to arrange shift swaps as they work a 24-hour pattern compared to the fixed rota for FYs. They believe the rota and recent changes to the rota are impacting logbook numbers and elective clinics. The rota is also impacting resident doctors' wellbeing.

2.14 Handover (R1.14)

F1: F1s reported undertaking peer-peer handover of sick patients and jobs that require urgent attention. They reported no formal handover document however there is a job book, and handover does not have ST or consultant oversight. They noted a trauma meeting as taking place in the morning which reviews new admissions and those going to theatre and a nursing handover which would be useful for F1s to attend. They also noted limited interaction with the ortho-geriatric team who routinely only see patients once unless a patient requires follow up or are admitted long term. Ward rounds are held however they do not include FYs and job book tasks are often not picked up. They explained that STs are teams based, they look after patients that come under their team and handover is within those teams, unfortunately F1s are not teams based and look after all patients. They believe there is a lack of continuity of care and tasks can often be missed as they are co-ordinating between so many different teams. They would find it useful to have an up-to-date handover document to which they could refer.

F2: F2s reported that weekday handover requires some work. Handover is informal due to the number of patients across the 2 wards which regularly results in tasks being missed. An example was provided of a nurse requesting review of a patient who had been admitted overnight, and the night team had not made the ward aware of them. They find the job book has helped however recognise there are still issues with it also. They noted handover as being F1 to F2 with no ST or consultant leadership. They noted a 5pm handover as taking place where juniors can ask seniors questions however it is out with their working day as they finish shift at 5pm.

ST: STs commented that handovers take place at 5pm and 8.30pm however the 5pm handover is often delayed. They believe there is a structure to how patient information is handed over and described the use of a proforma which is followed each day. They also consider handover to provide safe continuity of care for new admissions and for those in downstream wards.

2.15 Educational Resources (R1.19)

F1/F2/ST: Not asked, no concerns raised in pre-visit questionnaire.

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

F1: F1s are unsure as to what support is available to them should they be struggling with any aspects of the job or their health.

F2: Not asked, no concerns raised in pre-visit questionnaire.

ST: STs reported that the formal route for support should they be struggling with any aspects of the job is through their clinical supervisor and the management team. They are aware of procedures being in place and that referrals can be made to occupational health.

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

F1/F2/ST: Not asked covered in section 2.11.

2.18 Raising concerns (R1.1, 2.7)

F1: F1s reported they would raise any concerns regarding patient safety with their supervisor. They noted that all consultants are approachable and receptive to hearing their views.

F2: F2s reported that patient safety concerns would be escalated to the registrar and named consultant for that patient. They noted that there is no structured ward round with the different teams to give clear senior leadership. For patients who are medically unwell there is good access to the medical registrar and critical care team. There is also a very useful critical care handbook.

ST: STs stated that concerns regarding patient safety are taken very seriously by the department. The official route for reporting concerns would be via the datix system with further discussion at an M&M. They are also confident in raising any informal issues with consultants.

2.19 Patient safety (R1.2)

F1: F1s reported that there is a process for boarding patients and believe that most who are boarded out are fit to do so. They noted that problems can arise with where patients are boarded to and are not always confident that these patients are being reviewed as often as they should be. They are often asked if patients can be boarded however note this is not a decision that they would make and would refer this to the registrar. They noted often receiving calls from HDU stating that patients have had no registrar review that day.

F2: F2s stated that should a friend or relative be admitted to the department they would receive first class orthopaedic care however there is a potential that medical issues can be missed especially within the first block.

ST: STs reported that patients are rarely boarded out with the wards and for those who are boarded out they tend to require less surgical intervention and more medical intervention. They noted that registrar opinion has been ignored on occasion and patients have been moved and had to be brought back. They agree that there is a need for more robust reporting of registrar plans. Boarders are seen every day and the ANPs print a boarders list which is reviewed at 5pm and 9pm, they consider this to be a robust process. Concerns were noted relating to stepdown from the acute setting to rehabilitation with RDIT within Woodend hospital receiving no notice of patients being transferred. There is also no mechanism to track those patients to move to Woodend hospital.

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

F1: F1s confirmed they are aware of the datix reporting system for adverse incidents. Support provided from seniors can very much depend on the incident; however, they do believe if they were involved in an adverse incident they would be listened to and supported.

F2: Not asked, no concerns raised in pre-visit questionnaire.

ST: STs reported that they are aware of the datix reporting system for adverse incident and discussion and learning from such events through M&M. They are confident they would be well supported by consultants if they were involved in an adverse incident.

2.21 Other

Overall Satisfaction Scores: n/a.

3. Summary

Is a revisit required?	Yes	No	Dependent on outcome of action plan review
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The panel noted serious concerns relating to the learning environment and culture and educational governance and support. The panel also noted positive comments relating to induction, departmental teaching and team culture. Areas for improvements were noted as rota, support, handover and feedback. SMART objectives and action plan review meetings will be arranged in due course where the department will be given the opportunity to show progress against the requirements listed within this report.

Serious concerns:

Learning environment and culture

- Persistent and serious patient safety concerns.
- Significant risk to resident doctors' safety at all levels.
- Learning environment does not support orthopaedic doctors in training achieving their curriculum outcomes.

Educational governance and leadership

- Local quality management processes alone are failing to find solutions to address concerns relating to patient safety, standard of care and the standard of education and training.

Assurance that critical care decision making for T&O patients in HDU has direct senior clinical input and support always available to resident doctors in training.

Positive aspects of the visit:

- F2s noted that the trauma and critical care handbooks are useful.
- FYs appreciated efforts made by F2s and clinical development fellows (CDFs) in providing a programme of departmental teaching which is of good quality.
- Excellent focused departmental teaching for STs.
- All RDITs reported that consultants, advanced nurse practitioners (ANPs), CDFs, nursing staff and the rota co-ordinator are approachable and supportive.
- All RDITs recognise that the team are doing their best to provide a good training environment and experience in face of high workload.
- FYs reported clear escalation processes for support from medical specialties and the critical care team.
- FYs reported no difficulties in achieving curriculum competence and obtaining supervised learning events (SLEs).

Less positive aspects of the visit:

- Significant concerns were identified regarding FY and ST input to the surgical HDU unit. F1s are being asked to make clinical decisions and deliver care out with their level of competence and are managing patients for significant periods without direct supervision. The STs are also managing patients out with their level of competence. This poses a risk to the safety of patients and the resident doctors in training.
- STs are failing to achieve their curriculum competencies due to the workload in trauma. On elective blocks they cannot attend sufficient outpatient clinics and elective theatre lists. On trauma blocks operating experience is impacted by zero days. STs are regularly undertaking activity on zero days to compensate for these effects. This is an additional risk to RDIT safety.
- There is no specific departmental induction for F2s coming from Woodend to ARI and patchy induction at ST rotation.
- FYs unable to attend most departmental teaching sessions and only 20%-50% of regional teaching sessions due to intense workload.
- FYs noted that as patients come under different teams it can be challenging to get timely support due to seniors being in theatre or the emergency department.
- The system for boarding internally in ARI is effective but there is no system for tracking orthopaedic patients who are moved downstream to elective/rehabilitation wards.
- All RDITs reported no SPA time and there for no opportunities to undertake QI or audit.

- The rota changes for FYs are not robust when there is sickness when there is still at times one FY on duty OOH.
- The rota changes for the STs have improved workload and safety on trauma shifts but have had a negative impact on overall experience and achievement of curriculum competencies.
- The duties undertaken by STs include significant administration related to major trauma which affects time available for training and could be carried out by other individuals.
- F1s reported no formal or structured handovers taking place at ward level that includes senior supervision. Handover is peer to peer F1 with no written handover record kept and there is no learning from handover. Job book tasks are not being picked up.
- F2s reported limited feedback on day-to-day work.
- Ortho-geriatric input is limited; FYs are not invited to be part of ward rounds these are held with ANPs only.

4. Areas of Good Practice

Ref	Item	Action
		n/a

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	The system for boarding internally in ARI is effective but there is no system for tracking orthopaedic patients who are moved downstream to elective/rehabilitation wards.	n/a
5.2	The rota changes for FYs are not robust when there is sickness when there is still at times one FY on duty OOH.	n/a

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	Resident Doctors in training must not be expected to work beyond their competence in the HDU area.	Immediate	All
6.2	Review and clarify the Clinical Supervision arrangements to ensure a clear understanding of who is providing supervision and how the supervisor can be contacted for all surgical team.	Immediate	Foundation
6.3	The Board must design rotas to provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme.	Immediate	ST
6.4	Resident doctors must receive adequate induction to all sites they cover during the day and out of hours which ensures they are aware of all their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation.	Immediate	Foundation
6.5	Handover processes must be improved to ensure there is a safe, robust handover of patient care.	6 months	Foundation
6.6	The daily working pattern for ST doctors must provide adequate time for SPA activity such as QI/research	3 months	ST
6.7	There must be active planning of attendance of doctors in training at departmental and regional teaching events to ensure that workload does not prevent attendance. This includes bleep-free teaching attendance.	6 months	Foundation
6.8	A process for providing feedback to doctors in training on their input to the management of cases must be established. This should also support provision of WPBAs.	6 months	Foundation