Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	15th July 2025	**Level(s)**	Foundation, Core, Specialty
Type of visit	Immediate Triggered (virtual)	**Hospital**	Borders General Hospital
Specialty(s)	General Surgery	**Board**	NHS Borders

Visit Panel	
Dr Fiona Drimmie	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Fiona Cameron	Foundation School Director, Associate Postgraduate Dean (Foundation East)
Professor Alan Denison	Lead Dean Foundation
Dr Hazel Halbert	Training Programme Director
Mr Eddie Kelly	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Jennifer Gierz	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 & Mr Phil Walmsley
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Ms Vhari Macdonald
Unit/Site Information	
Trainers in attendance	4
Resident Doctors in attendance	11 (9-F1, 1-Core, 1-ST)

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

Report approved by Lead Visitor / Lead Dean	Dr Fiona Drimmie Professor Adam Hill Professor Alan Denison

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 the wellbeing of resident doctors in training (RDITs) within General Surgery at Borders General Hospital therefore a Deanery Immediate Triggered Visit has been scheduled.

Themes:

- Discrimination
- Equality & Inclusivity
- Team Culture

NTS Survey Data (2024):

All Trainee General Surgery – All White.

Core CST/ST General Surgery – All Grey.

F1/F2 Surgery – All Grey.

STS Survey Data:

November 2024

All Trainee General Surgery – All Grey.

August 2023-July 2024

All Trainee General Surgery – Red Flag – Induction. Pink Flag – Discrimination.

Core Surgical Training/Core General Surgery – All Grey.

Foundation – All White.

Department Presentation:

The visit commenced with Mr Martin Berlansky, Clinical Lead delivering an informative presentation to the panel. This focused on concerns raised by F1s and highlighted themes, contributing factors, challenges and next steps. Details were also provided on work that has taken place to date.

2.1 Induction (R1.13):

Trainers: Trainers reported that the induction handbook has been updated and is e-mailed to RDITs 2-weeks prior to commencing in post. On the first day in post there is a hospital induction session followed by a 1-hour surgical departmental induction. This includes a run through of the induction handbook, expectations, structure of the department, theatre, scrubs, rota, frequent clinical scenarios, time for questions and a tour of the ward. Individual consultant lead induction sessions are arranged as quickly as possible for anyone who has missed the formal session.

F1/CT/ST: RDITs reported receiving good quality hospital induction. Most confirmed receiving an informal departmental induction however F1s commented that it did not equip them well to work in the department and no induction handbook was provided. F1s commented that notes left from previous F1s were extremely useful. They suggested that information on daily duties and shift patterns would be useful to include in future induction sessions. An example was provided of a post-op patient with a compromised airway; they sought support from a registrar working close by as they regularly experience lengthy delays in getting support through the emergency number. They stated that they were unaware that protocol is that this should have had an emergency procedure on the ward and did not feel equipped to deal with this scenario.

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

Trainers: Trainers reported that there is a hospital wide teaching programme on a Thursday which RDITs are encouraged to attend. Departmental teaching takes place on a Wednesday which includes regular simulation and surgical skills sessions. There is a consultant who is designated lead for international medical graduates (IMG), with additional bespoke teaching sessions arranged.

F1CT/ST: F1s reported receiving one hour of regional teaching per week and noted measures put in place to ensure bleeps are covered to allow attendance. Core (CT)/ST reported that there is no regional teaching programme for General Surgery. RDITs stated there is no departmental teaching programme.

2.3 Study Leave (R3.12)

Trainers: Trainers reported no challenges in supporting study leave requests which are made in a timely manner. F1s can also request Tasters which the department are happy to accommodate.

CT/ST: RDITs reported no problems in requesting or taking study leave and find the system easy to use.

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

Trainers: Trainers noted that educational and clinical supervisor allocations are made by the Medical Education Team which are confirmed via e-mail prior to RDITs commencing in post. They are recognised trainers with time in job plans for supervisory roles however noted difficulties in juggling supervision with clinical commitments. They commented that RDITs are responsible for arranging initial supervisor meetings and are encouraged to do so are early as possible. Information relating to RDITs with known concerns is shared with the clinical lead who will in turn share with the relevant supervisor. Reasonable adjustments to training have also been supported by the department in the past. They noted that a process is in place for escalating concerns relating to an IMG which is through the lead consultant. Concerns with F1s are escalated via the Medical Education Team.

F1/CT/ST: Most RDITs reported no concerns in meeting educational supervisors and setting formal meetings and noted available consultants who checked in regularly. Some F1s reported difficulties with some supervisors where meetings were informal, and some seniors lacked an understanding of curriculum requirements. Several examples where RDITS stated they were bullied and undermined were provided.

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 escalation pathways are included in the induction handbook. These are also discussed within initial meetings along with on-call and supervision arrangements to ensure RDITs understand the process. They described the clinical escalation pathway as F1 to registrar and registrar to consultant and described a robust structured handover system. Morning handover is attended by the previous day's registrar, the registrar on-call, consultant on-call and F1 where all patients are discussed. They commented that if RDITs believe they are having to cope with problems beyond their level of competence they would express this in their feedback and believe these instances are related to the way in which support was provided. They acknowledge this is an area for improvement and confirmed work is underway to try and address this. They believe that adequate support is always available. They confirmed that CT and ST RDITs only seek consent for procedures they are competent to undertake and that consultant support is always available. It is not a requirement for any F1s to undertake a procedure that requires consent.

F1/CT/ST: RDITs confirmed being aware of who to contact for clinical supervision both during the day and out of hours. CT/ST noted easy escalation pathways directly to the on-call consultant. F1s reported difficulties in accessing support especially when seniors are in theatre and raised serious concerns regarding clinical supervision on the wards. They commented that support from CT/ST is good if they are in theatre they have someone answer the bleep or invite them to theatre to discuss concerns however they noted varying levels of support from permanent members of staff with some who refuse to answer calls. Examples of repeatably calling for support with no response were provided or there being lengthy delays and some seniors being annoyed at being disturbed to attend the ward. They noted a high level of support during the day as being provided by the critical care outreach team when they are unable to seek appropriate surgical support. The critical care outreach team are available between 9am - 5pm and concerns were noted regarding their ability to get appropriate levels of surgical support outside these hours. An example was provided of anaesthetics on-call requiring patients to be reviewed first by the surgical registrar before they will help. RDITs stated that they regularly must deal with problems beyond their level of competence mainly because of lack of clinical supervision. CT/ST reported occasionally having to cope with problems beyond their level of competence when they are first on-call for General Surgery and have to cover Breast Surgery, Urology, Vascular, Neurosurgery, Oral and maxilla-facial Surgery, Otolaryngology and Colorectal. They noted no handover document that describes referral pathways for these subspeciality areas.

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

Trainers: Trainers reported that although they are familiar with the different RDIT curricular and would welcome updated training to ensure their knowledge is up to date and includes any recent changes. They confirmed that within initial supervisor meetings they discuss requirements and

assessments for the post including specific number of clinics and operative cases. They noted that CT/ST are scheduled into theatre regularly and try to bleep them if they are aware of any specific procedure they have not had the opportunity to undertake. They believe that all surgical procedures, ward rounds and patient discussions are of educational benefit to all RDITs. Once ST3s are competent in procedures they are encouraged to undertake ward rounds. F1s take notes and observe the consultant within ward rounds. They are also given the opportunity to examine and assist with procedures.

F1/CT/ST: RDITs reported that the post has allowed them to develop skills and competence in managing acutely unwell patients. RDITs commented that the majority of their is spent carrying out duties that are of little or no benefit to their education and training. F1s stated that they have regularly had to step up to the challenges of regularly working alone and having to take on responsibilities that are beyond their level of training. CT/ST noted limited opportunities to attend clinic and theatre sessions due to heavy demand to cover on-call due to staffing issues. Hot clinics allow training requirements for the CT to be met. Concerns regarding clinic and theatre allocation have been escalated numerous times.

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

Trainers: Not asked due to time constraints.

F1/CT/ST: RDITs noted difficulties in obtaining some competence, intended learning outcomes and workplace-based assessments in post. F1s noted difficulties were due to rarely reviewing patients with specialty doctors. Assessments are completed by the same few registrars.

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

Trainers/F1: Not asked due to time constraints.

CT/ST: RDITs noted no opportunities to learn with other health professionals in the team as there is no ward pharmacist and no departmental teaching programme.

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

Trainers: Trainers reported CT and ST RDITs have time within the rota to undertake quality improvement and audit projects which is initiated by the RDITs.

F1/CT/ST: F1s stated that there is no guidance or surgical support for undertaking a quality improvement project in post. CT/ST commented that it is easy to take part in a quality improvement project in the department however there is insufficient time to do so due to covering sick leave. They noted excellent support from the IT department in providing data.

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

Trainers: Trainers stated that due to the structure of surgical training discussion and feedback are incorporated into all aspects of work. They discuss with RDITs what is expected of them, what went well and what didn't go so well this format is followed in the ward and within theatre. Feedback on cases is also provided within morning handover where consultants highlight positives and what could have been done differently. There are also formal feedback opportunities within the different RDIT portfolios.

F1/CT/ST: F1s from block 2 (December 2024 – April 2025) reported receiving very little individual feedback. They noted a poor team culture with regular unprofessional behaviours from seniors. Examples were provided of e-mails being sent to groups highlighting individual mistakes and being reprimanded for not completing tasks where instructions were unclear and of feeling attacked. F1s from block 3 (April 2025 – August 2025) noted some improvements and confirmed receiving regular constructive and meaningful feedback. They acknowledge examples provided by their peers and noted some of the poor behaviours in the more senior medical team as ongoing. They commented that around 90% of daily tasks for F1 are generated from handover and ward rounds with 10% coming from management plans they have created for acutely unwell patients. The CT/ST noted receiving constructive and meaningful feedback within morning handover as they regularly present cases. They consider handover to be structured and safe.

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

Trainers: Trainers reported that feedback from RDITs on the quality of their training is welcomed by the team. They noted that RDITs can provide feedback through various avenues such as the clinical lead, clinical supervisor, foundation programme director (FPD), training programme director (TPD) or as a group via the chief resident. There is also a 6-weekly meeting to which all staff are welcome to attend.

F1/CT/ST: F1s stated they were unsure of any formal opportunities to provide feedback to trainers or the management team on the quality of their training. They are aware of the teaching fellow, medical education team and of weekly M&M meetings. They commented that it can be difficult to give feedback and would not be comfortable in doing so with clinical supervisors. They stated that this was a result of the culture in the department and fear of being reprimanded if they were to raise any concerns. CT/ST acknowledged difficulties in raising concerns regarding team culture, bullying and undermining within a small team. They confirmed they would be comfortable discussing patients with the on-call consultant and any training related issues with their TPD or through the deanery.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that they try to ensure the training environment is free from undermining and bullying behaviours. They noted that as a group they have discussed scenarios that could be perceived as bullying and undermining and provided constructive feedback on these. They believe contributing factors can be in the delivery of feedback where tone, language and body language should be considered. There may also be cultural differences that could be misconstrued as bullying. RDITs should raise any concerns relating to bullying or discrimination with supervisors or the clinical lead which is highlighted to them within induction sessions. Trainers acknowledged very recent feedback received which has been escalated to the medical director.

F1/CT/ST: RDITs reported a culture of bullying and undermining within the department. Examples provided are being shared out with the report with the Director of Medical Education and Medical Director.

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

Trainers: Trainers stated that the rota is designed for F1s. The rota is held in an excel spreadsheet with 5-6 people and is e-mailed in advance by the Human Resources (HR) team. All RDITs are

requested to contact their rota co-ordinator regarding requests for annual leave and study leave they are encouraged to facilitate swaps with peers. There are planned improvements to the F1 rota which will take effect from August 2025. They consider the rotas to be accommodating and note the considerable effort made by the rota co-ordinator to try and accommodate requests.

F1/CT/ST: RDITs stated there are no gaps in the rota apart from short term sickness gaps. They explained that there is an F1 rota and a registrar rota which includes the CT, ST, specialty doctors and clinical fellow. The F1 rota was received less than 2 weeks before they commenced in post and there were no opportunities to request annual leave. Changes that were required were made after the rota was issued and were arranged with peers. Concerns were raised regarding the intensity of the rota and working hours. They provided examples of 7-day week covering 70 hours with 4 members of staff, going from nights to 12-hour shifts with no rest day to 4 normal days and 3 long days. They believe aligning to the pattern followed by consultants for 7-day stretches would be of benefit. CT/ST noted long term sickness gaps in the rota, they regularly try to fill gaps with a pool of external locums. They noted regularly working late to allow handover to the hospital at night team (H@N) to avoid being called later. They have also stayed within the hospital after shift as they have considered themselves to be unsafe to drive.

2.14 Handover (R1.14)

Trainers: Trainers consider handover arrangements to provide safe continuity of care for new admissions and downstream wards. They described morning handover as taking place at 8.30am in the seminar room where all surgical patients in the department are discussed. The TRAK system is used, and the surgical registrars presents cases from overnight. They consider handover to provide good learning opportunities.

F1/CT/ST: RDITs reported well-structured morning handover where all patients are reviewed, and any concerns can be raised for discussion. Handover can be used as a learning opportunity as scans are reviewed and there are opportunities to ask questions however, they noted you must be confident to do so as it can be an intimidating environment. Handovers on occasion can be cut short to allow consultant to go to theatre. There are no formal weekend handovers due to no crossover in rotas. On a weekend F1s receive a short handover of new admissions and acutely unwell patients only from the H@N team. They consider handover to provide safe continuity of care for new admissions however

do not consider ward rounds to be as safe these are fast paced and F1s can still be taking notes when the rest of the team have moved onto the next patient.

2.15 Educational Resources (R1.19)

Trainers: Not asked due to time constraints.

F1/CT/ST: RDITs commented on an excellent library but noted that they have no time to use the facilities. There is also a small registrar room with 3 computers for 8 people.

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 asked due to time constraints.

F1/CT/ST: F1s stated that they would approach their FPD or the medical education team if they were struggling with any aspects when in post. They believe that reasonable adjustments would be considered however may be difficult to deliver in a small department.

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/F1/CT/ST: Not asked.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that RDITs are asked as part of morning handover if they have any patient's safety concerns. Ward rounds also take place twice a day RDITs are asked if they have any comments on management plans and if there are any patients they have concerns with. This was an area they recognised as requiring improvements which have been implemented to ensure a robust process is in place.

F1/CT/ST: F1s reported difficulties in accessing immediate surgical support and noted often seeking support from the anaesthetics and critical care outreach teams which is excellent. CT/ST confirmed they would raise any patient safety concerns with the clinical director.

2.19 Patient safety (R1.2)

Trainers: Trainers stated that they have recently spent time reflecting on a cluster of difficult past surgical cases that may have prompted negative feedback. Work has been undertaken on improving team culture and communication between consultants which they believe has shown improvements over that last 6-months.

F1/CT/ST: RDITs stated they would have concerns if a friend or family member were to be admitted to the department. Some commented that their answer would be dependent on the senior they were on-call with. They reported significant concerns with the system for boarding trauma and orthopaedics (T&O) and medical boarders into the surgical department. They noted no formal protocols or guidance on the management of these patients, no handover from medical boarders' team and no escalation pathways. They noted a lack of understanding in where responsibility lies for some actions such as transfer of patient care. They provided examples where there has been no review of patients by parent teams in T&O and medicine for lengthy periods of time. They commented on often feeling out of their depth with these patients and noted difficulties in contacting parent teams with bleeps for T&O and medical boarders rarely answered. CT/ST noted that they have little involvement with boarders however are aware of a daily safety briefing which takes place every morning with the manager and clinical director. This does not involve any RDITs.

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

Trainers: Trainers reported that should something go wrong with a patients care the consultant, or registrar would discuss with patient's family in a private area and the F1 would attend to document discussions. On most occasions a consultant would accompany the registrar to support discussions or lead should the registrar not feel confident to do so.

F1/CT/ST: RDITs confirmed they are aware of the datix reporting system for adverse incidents however examples were provided of some being discouraged from using the system. Often internal investigations can take place however they receive no feedback or learning from such events. They reported relying on the critical care outreach team for support and noted difficulties in accessing appropriate support on ward 7. They also reported having to deliver news to a patient they believe was out with their level of competence. They noted a reluctance from some consultants to deliver bad news and believe communication could be improved.

2.21 Other

Overall Satisfaction Scores: n/a.

SAS Doctor/Specialty Doctor/Clinical Development Fellow Session

Induction: Doctors noted receiving hospital induction however did not receive specific induction to the department. They reported contributing to F1 induction.

Teaching: Doctors stated that they do not attend RDIT teaching however there is an SAS development fund which they can access to support things such as supervision courses and master's degrees. They noted departmental teaching as taking place on a Tuesday and a continued medical education meeting as taking place on a Wednesday. There is also a joint departmental meeting with Radiology where F1s are given the opportunity to present.

Supervision: Doctors reported being very well supported in their roles and noted undertaking supervision training to allow them to provide supervision for RDITs.

Feedback: Doctors reported providing feedback to the clinical director on the quality of their post. Concerns within the department were escalated to the clinical director who attempted to progress things however there was no resolution.

Workload: Doctors stated that the rota had been reviewed several times. They noted being on the same rota as the CT, ST and a clinical fellow. The rota is tight, and the 24-hour on-call shift is intense. They commented that they believe it is inappropriate that a CT is expected to work at the level of an ST and that better support should be provided to them.

Culture and Undermining: Doctors reported variable level of support from seniors. They noted significant difficulties for RDITs in accessing support and expectations placed on speciality doctors. They recognise the immense pressure F1s are under on the ward, they ask for support however difficulties arise as there is no middle tier within the rota. The noted that as a group they have their own commitments and responsibilities with varying levels of on-call support and that some refuse to provide support. They confirmed that they have witnessed and been subject to behaviours that have undermined confidence. They consider most of the team to be supportive however acknowledge that there are unresolved issues in the team. They provided examples of people being berated in

meetings, being told they are stupid, sexist remarks being made and regular bullying. They commented that issues have been raised with the management team who were supportive however issues were taken no further and handed back to the department to address. They have noticed minimal improvements to behaviours in the few months prior to the visit.

Patient Safety: They believe in general the department is safe however this varies depending on which senior is on-call.

Adverse Incidents and Duty of Candour: They noted generally feeling well supported in communicating difficult news to a patient. They did however comment that due to strained internal relationships there is a refusal by some to interact with specialty doctors. They noted Mr Berlansky and Mr Pal as being very supportive.

3. Summary

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

The panel commended the engagement of the site and medical education team in supporting the visit and noted the considerable efforts being made to improve training. Serious concerns were raised relating to support, patient safety and wellbeing which were discussed with the Medical Director and Deputy Medical Director immediately after the visit. The panel also noted positive comments relating to induction, teaching, adverse incidents, supervision, assessments and feedback. Areas for improvements were noted as rota, handover and boarders. 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 (discussed with MD 15th July 2025)**:**
Themes – Learning environment and culture. Educational governance and leadership.

- Assurance that timely clinical senior advice and support is always available to F1s, particularly out of normal working hours.
- Review of Boarding arrangements of non-surgical patients into the surgical ward such that there is clear responsibility for their care.

- Resident doctors must be treated with kindness, courtesy and respect.
- Further discussions will be undertaken to determine if enhanced monitoring is appropriate.

Positive aspects of the visit:

- Excellent engagement from the Medical Education team and site management team in supporting the visit.
- Recognition of efforts and engagement to make sustainable improvements.
- Resident doctors in training (RDITs) described robust hospital induction.
- RDITs reported attending the majority of regional teaching sessions.
- F1s noted improvements in communication and being provided with constructive feedback.
- RDITs reported structured and safe handover during the week with opportunities to discuss cases.
- CT and ST RDITs reported working closely with educational supervisors who they meet formally 3 times in a 6-month post with regular opportunities for informal discussions.
- CT and ST RDITs noted good opportunities to be involved with quality improvement projects which are well supported.
- Arrangements and support available for IMG doctors.
- F1s noted good support from anaesthetics and the critical care outreach teams, although this has been impacted with a recent reduction in working hours.
- Support for the professional development of locally employed doctors.

Less positive aspects of the visit:

- Multiple examples of concerning behaviours at multiple tiers in the medical structure which have persisted for a considerable period of time and have not improved despite a number of interventions. This has adversely impacted on multiprofessional team culture, training and wellbeing.
- There is a reluctance to raise concerns with some feeling unable to speak up due to a perception they may be treated adversely. Those who raised concerns believed there was little action taken and do not feel they were listened to.

- While an action plan was welcomed, it was unclear if there is sufficient local and wider organisational commitment to deliver and sustain the changes required.
- Not all RDITs received departmental induction and no handbook was provided.
- RDITs reported that there is no departmental teaching scheduled.
- F1s noted difficulties in obtaining workplace-based assessments due to rarely seeing patients with seniors because of the way in which the clinical service is organised.
- Some RDITs reported being unable to undertake sufficient curriculum-related activity on account of rota design, service obligations and wider team dynamics.
- RDITs reported working difficult rotas with long stretches and few rest days.
- F1s reported that there is no formal structured handover at weekends.

4. Areas of Good Practice

Ref	Item	Action
4.1	F1s noted good support from anaesthetics and the critical care outreach teams, although this has been impacted with a recent reduction in working hours.	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

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	Trainees must be provided with clearly identified seniors who are providing them with support during the day and out of hours for all clinical areas they cover and must never be left dealing with issues beyond their competence.	Immediate	F1
6.2	The department must have a zero tolerance policy towards undermining behaviour. All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines. Specific example of undermining behaviour noted during the visit will be shared out with this report.	Immediate	All
6.3	The site must develop an effective system of safe selection, tracking and managing boarded patients and ensuring appropriate clinical ownership, escalation pathways and oversight of patient care with subsequent monitoring of the policy's impact and effectiveness.	Immediate	F1
6.4	Departmental induction must be provided which ensures trainees are aware of all their roles and responsibilities and feel able to provide safe patient care including downstream wards, OOH and weekends. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation.	December 2025	All
6.5	The department must develop and sustain a local teaching programme relevant to curriculum requirements of all resident doctors in training including a system for protecting time for attendance.	December 2025	All

6.6	There must be senior support, including from consultants/recognised trainers to enable doctors in training to complete sufficient WPBAs/SLEs to satisfy the needs of their curriculum.	December 2025	F1
6.7	The on-call rota pattern must be reviewed to provide learning opportunities that allow resident doctors in training to meet the requirements of their curriculum and training programme.	February 2026	CT/ST
6.8	The rota structure is perceived to be too demanding because of a lack of down time between nights and long days and this must be addressed.	December 2025	All
6.9	Weekend handover must be formalised and happen consistently in all ward areas to ensure safe handover and continuity of care and must be scheduled within the rostered hours of work of the resident doctors in training.	December 2025	F1