

Scotland Deanery Quality Management Report

Date of meeting	23 rd June 2026	Level(s)	Foundation, Core, Specialty
Type of visit	Triggered Visit	Hospital	Queen Elizabeth University Hospital (QEUH), Glasgow Royal Infirmary (GRI), Royal Alexandra Hospital (RAH), Inverclyde Royal Hospital (IRH), Royal Hospital for Children Glasgow (RHCG), Golden Jubilee National Hospital (GJNH)
Specialty(s)	Foundation, Core, Specialty	Board	NHS Greater Glasgow & Clyde

Visit Panel	
Dr Fiona Drimmie	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Kerry Haddow	Quality Associate Postgraduate Dean
Dr Jane Rimer	Medical Training Associate Postgraduate Dean
Dr Shona MacLellan	Foundation Associate Postgraduate Dean
Mrs Sarah Summers	Lay Representative
Mrs Patriche McGuire	Quality Improvement Manager
In Attendance	
Mrs Susan Muir	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,
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Ms Vhari Macdonald

Unit/Site Information	
Trainers in attendance	19
Resident Doctors in attendance	40 (FY – 14 , CT/ST1+2 – 3 , ST3+ - 23)

Feedback session: Managers in attendance	Chief Executive	0	DME	2	ADME	3	Medical Director	2	Other	23
Report approved by Lead Visitor / Lead Dean		Dr Fiona Drimmie Professor Adam Hill Mr Alastair Murray								

1. Principal issues arising from pre-visit review:

Following local intelligence, it was agreed to conduct a triggered visit to all Trauma & Orthopaedic (T&O) departments within West of Scotland.

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.

Department Presentation:

The visit commenced with Dr Colin Perry & Dr Lorna Swan, Director of Medical Education for GG&C & GJNH delivering an informative presentation to the panel. This focused on what is going well, what could be improved and what the next steps were for each site. Dr Perry also spoke to the GG&C wide approach of raising concerns with Resident Dr meetings co-chaired by Deputy Medical Directors for GG&C and PSDS, "Active Bystander Training for tackling Sexual Misconduct in Healthcare," and QR codes directing RDiT to various resources for reporting concerns and support.

2.1 Induction (R1.13):

Queen Elizabeth University Hospital

Trainers: QEUH noted that providing a full induction for FY1 doctors remains challenging. FY1s attend a trust-level hospital induction, after which trainers meet with them for an hour to offer key information and outline available support. FY2, CT and ST RDiT receive an online induction link along with slide materials, and an induction booklet is distributed six weeks before their start date, although it is unclear how consistently RDiT engage with this resource. Trainers confirmed they proactively update the induction materials on an annual basis to ensure it is relevant and up to date. Individuals who are unable to attend induction are subsequently offered one-to-one meetings.

RDiT (All grades): At the QEUH, most RDiT reported a positive experience, describing the departmental induction as well organised, comprehensive and supported by pre-arrival paperwork. However, experiences were not consistent, with some individuals indicating that they did not receive a departmental induction and others reporting that no induction was provided when commencing their placement. Some CT/ST doctors noted that, even where they had previously worked at the site, an updated induction would still have been valuable to familiarise them with current processes and service arrangements.

ST RDiT identified gaps in hospital induction content, particularly relating to practical aspects of day-to-day working. Areas highlighted included access to IT systems, referral processes, local working practices and general logistical information.

Glasgow Royal Infirmary

Trainers: GRI reported that its induction approach varies according to the level of the RDiT, with many already familiar with the hospital environment. Both departmental and corporate inductions follow a structured format, providing online resources, contact information and written departmental protocols accessible to all RDiT. The induction is delivered by consultants and is designed to cover all essential information. It is typically held on a Wednesday, although sessions may also be arranged on Thursdays or Fridays when required.

RDiT (All grades): Some RDiT reported being unable to attend their scheduled induction, and although rota information was provided in advance, there was limited supporting documentation and little opportunity for follow-up induction. In some cases, follow-up was offered but RDiT admitted they did not take up these opportunities if they were already familiar with the site.

There were reports of planned departmental inductions being disrupted, resulting in only a brief introduction and tour being provided. Some doctors felt they developed an understanding of departmental processes only after beginning work. While an induction handbook had been circulated in advance, it was considered to be outdated. Those who received departmental induction at GRI generally felt it was reasonable and provided an adequate introduction to the department.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Trainers: RAH reported that their induction programme is delivered in two parts, with one session covering RDiT from FY to ST2 and a separate session provided for those at ST3 level and above. They noted that the volume of information presented can feel overwhelming, and although they trialled a staggered approach to reduce this, RDiT expressed a preference for receiving all information at once.

IRH deliver induction one-to-one, with staff reviewing the required materials directly with each RDiT. It was noted that with catch up inductions external contributors (such as pharmacy) speakers are occasionally missed due to scheduling constraints, though efforts are made to incorporate their contributions whenever possible.

RDiT (All grades): Induction experiences at RAH were generally positive but not entirely consistent. Some RDiT reported that they did not receive a hospital induction, while others felt that important practical information and guidance were lacking. Despite this, departmental induction was consistently provided at the start of placements and was regarded as sufficient.

While the departmental induction at RAH was viewed favourably, some orthopaedic RDiT felt that inductions at associated peripheral sites which they attend intermittently (IRH & Vale of Leven) could have been more tailored and site-specific to better prepare them for local processes and working arrangements.

Royal Hospital Children Glasgow

Trainers: RHCG site reported that its induction programme comprises a full morning of hospital-wide induction followed by an afternoon session focused on the team's handbook, which RDiT can access whenever required. Clinical activity is cancelled to facilitate attendance, and the induction is delivered by consultants to ensure coverage of essential information.

RDiT: RDiT reported induction as a positive experience.

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

Queen Elizabeth University Hospital

Trainers: At QUEH the teaching programme is delivered jointly to FY1 and FY2 trainees on Wednesdays and functions effectively, while this cannot be made bleep free, ward staff are aware of teaching sessions. Attendance remains variable, with junior doctors not always engaging despite clear expectations and attempts to monitor attendance. A rotation-wide programme, including full-day formal teaching for CT and ST3+ trainees, is supported by efforts to minimise elective activity, with no significant concerns identified; trauma activity which cannot be reduced is targeted for support by non-training grade staff. Locally, ongoing efforts to establish a structured trauma teaching programme have been hindered by poor attendance both in and out of hours, further work is being undertaken to understand and address the underlying causes of this low engagement.

Foundation: Some QUEH RDiT reported weekly teaching provision but advised they are unable to attend due to workload while others reported no formal teaching was in place.

CT/ST: Feedback indicated that the provision of formal teaching at QUEH was limited. RDiT reported an absence of a structured local teaching programme, with educational opportunities largely restricted to ad hoc sessions delivered by consultants. While previous attempts had been made to establish a more regular programme, these had not been sustained, and no formal teaching had been available for an extended period. Challenges associated with coordinating teaching at suitable times and accommodating complex timetabling were highlighted as a contributing factor to the inconsistent delivery.

Nationally organised teaching was reported to occur on a regular basis and was generally accessible for attendance.

Glasgow Royal Infirmary

Trainers: At GRI, non-training grade staff are utilised to support service provision and facilitate teaching attendance, with trainees expected to attend where possible. Local teaching is provided for Foundation, although attendance can be challenging due to service demands on the ward and the number of trainees. Within orthopaedics, there is a well-established daily trauma meeting attended by all staff, which provides a consistent teaching opportunity, particularly for senior trainees.

RDiT: Feedback indicated that formal teaching opportunities at GRI were limited and lacked a consistent structure. While some speciality-specific teaching sessions were available these were not

known about or recognised by all RDiT and it was noted that these occurred intermittently rather than as part of a regular programme. Mandatory teaching days were provided periodically and RDiT reported being supported to attend these through study leave arrangements and accommodation within their clinical duties. Although educational opportunities such as metalwork reviews were available, attendance was often difficult due to service commitments.

Access to regional teaching at all grades was viewed more positively, with attendance generally supported within the rota.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Trainers: At RAH/IRH, FY RDiT are supported to attend teaching through a bleep-free arrangement, with bleeps handed over to Clinical Development Fellows and Advanced Nurse Practitioners.

Departmental teaching is delivered weekly on Thursdays for foundation RDiT; however, attendance remains variable. Additional educational activity includes monthly audit meetings, morbidity and mortality discussions, and a journal club. No significant issues have been identified for registrar and middle grade teaching provision.

RDiT: RDiT reported that formal teaching opportunities were available but could be difficult to access consistently. Teaching was reported to be concentrated at RAH, with efforts made by individual consultants to provide regular educational sessions. However, service pressures frequently disrupted these arrangements, resulting in variable attendance and inconsistent delivery.

Additional educational opportunities included Metalwork review and Morbidity and Mortality meetings, although attendance at some sessions was challenging due to their delivery across multiple sites and competing clinical commitments.

Access to regional teaching was viewed positively, with RDiT reporting that attendance was generally well supported and could be achieved on a regular basis.

Royal Hospital Children Glasgow

Trainers: At RCHG, Foundation RDiT rotate through paediatric surgery and paediatric orthopaedics and are supported to attend teaching through a weekly Thursday morning bleep-free arrangement, with Advanced Nurse Practitioners holding bleeps. Senior RDiT are offered regular early morning teaching sessions from Monday to Wednesday, alongside access to regional protected teaching and monthly half-day CMD sessions. Additional learning opportunities include a weekly Friday afternoon peer review meeting, incorporating case discussions and x-ray reviews.

RDiT: At RCHG, RDiT reported a well-established teaching programme, including regular Wednesday teaching, structured sessions linked to trauma meetings, and peer review teaching on Fridays. RDiT are also able to attend regional teaching consistently, which was regarded as excellent. The timing of the early morning teaching sessions requires RDiT to work outside their scheduled hours which isn't always feasible and can exclude RDiT.

2.3 Study Leave (R3.12)

This question was not asked, no issues were identified through the PVQ responses.

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

Queen Elizabeth University Hospital

Trainers: At QEUH, a large cohort of trained educational supervisors who have completed the required preparation are supported in undertaking the role. RDiT are informed of their allocated supervisor in advance and are expected to take a proactive approach to engagement, with most supervisors responding promptly. Supervisors have devised a structured document to help guide initial meetings with Surgical RDiT.

For F2 trainees, supervision is organised through a pool of consultants familiar with the cohort. The predominantly surgical nature of the specialty presents some challenges for supervision, particularly within a large and complex unit where RDiT rotate between teams and can be less visible. To mitigate this, multi-consultant reporting is utilised to support continuity of supervision.

Glasgow Royal Infirmary

Trainers: At GRI, educational supervision has become more structured over the past five years, with increased involvement from supervisors and the introduction of a lead clinical supervisor role. RDiT are typically paired with a direct working colleague, with tools such as ISCP used to support development. Allocation of clinical supervision for Surgical RDiT is informed by initial discussions. The ward-based nature of FY roles can make supervision more challenging and feel "clunky," it places greater responsibility on RDiT to engage with their training. Certain supervisors work consistently with specific cohorts.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Trainers: At RAH/IRH, clinical supervisors are allocated externally by the TPD (as is the case across the programme) while educational supervisors for specialty RDiT are assigned locally. Foundation RDiT are allocated to a defined pool of trainers. RDiT are aware of escalation processes and feel able to raise concerns where required.

Royal Children's Hospital Glasgow

Trainers: At RCH, educational supervision is supported through job planning, ensuring supervisors are exposed to all trainees. Clinical Supervision of higher RDiT is shared across a group of eight consultants, 3 of which are linked to FY RDiT and CDF.

RDiT'S (All sites): RDiT at all sites reported no issues with formal supervision. They were allocated an educational supervisor and met with them at the start and mid-point of the post, with end-of-placement meetings planned.

Foundation RDiT: The arranging of end-of-block supervisor meetings can be problematic, with some RDiT struggling to organise these within the required timeframe.

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)

Queen Elizabeth University Hospital

Trainers: At QEUH, clinical supervision for FY RDiT is clearly established from induction, with structured ward-based cover and consistent consultant presence seven days a week. FY1 are supported by FY2s and on-call registrars during the working week, with clear escalation pathways to senior staff, particularly for complex medical or critical care concerns. Where there have been isolated concerns, including instances of limited support from FY2s or avoidance of responsibilities during out-of-hours work, these have been identified and addressed effectively.

Foundation: Feedback from QEUH indicates strong awareness of escalation processes, with accessible and supportive orthopaedic registrars and medical registrars who respond promptly and are willing to attend wards to provide assistance. Consultants were described as approachable.

CT/ST: Feedback from QEUH highlights consistently strong access to senior support, with registrars always available and multiple on-call consultants, facilitating straightforward and effective escalation.

Glasgow Royal Infirmary

Trainers: At GRI, clinical supervision has evolved in recent years from a two-tier to a three-tier system. FY doctors are now ward-based and paired in F1/F2 “buddy” arrangements, supported by front and back shift patterns to improve break compliance. A defined middle tier provides senior oversight, taking a leadership and problem-solving role and acting as the first point of contact for junior RDiT. Consultant support is available throughout the day, and trauma patients remain under the care of the admitting consultant, ensuring continuity.

RDiT (All grades): Feedback from GRI indicates reliable access to senior input, with registrars and consultants available during working hours and responsive on-call support overnight. Out-of-hours support remains available via pager, and registrars and consultants are considered easy to contact and helpful. It is noted that many issues encountered are not primarily orthopaedic in nature. The previous cohort reported, via the pre-visit questionnaire, minimal senior supervision and support however this appears to have been resolved. RDiT attending the visit had no concerns.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Trainers: At RAH, a clear escalation policy is in place and reinforced at induction, with guidance accessible across sites. A hybrid team structure supports close working relationships and ensures RDiT are clear on points of contact, further supported by daily registrar-led ward rounds of non-acute patients. Senior clinical fellows, a strong orthogeriatric team and middle grades contribute to supervision, and consultants are readily approached when required.

Foundation: Feedback from RAH and IRH highlighted initial difficulties in understanding the rota and correctly identifying the orthopaedic registrar. The RAH medical registrars are described as supportive and will provide advice as needed. Occasionally cross-site consultant working arrangements can create delays, for example after a receiving week at RAH inpatients will still be under the care of a consultant who is based at IRH the following week. This has occasionally caused delays such as wound reviews but will always be dealt with by the on-call team if needed.

ST: At RAH and IRH, there are generally no issues accessing consultant support, although a single instance was noted where a consultant listed on the rota was on annual leave; this received prompt support from an alternative on-call consultant.

Royal Hospital Children Glasgow

ST: At RCH, consultant support is described as accessible with no reported concerns.

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

Queen Elizabeth University Hospital

Trainers: QUEH indicate that overall training experience is considered adequate; however, engagement from consultants with Foundation Year curriculum requirements requires improvement. Recent rota developments, including the introduction of more FY1 posts and structured weeks in theatre, clinic and on call, have enhanced junior doctors' experience. Middle grade RDiT report excellent training opportunities, although higher RDiT feel that exposure to trauma is insufficient. Foundation/CT: QUEH RDiT report that obtaining workplace-based assessments is challenging due to high clinical workload, which impacts the timely completion and sign-off of tickets. Registrars are often occupied or off the ward, making it difficult to get tickets signed off. Some RDiT reported receiving appropriate access to theatre and clinics, although this is reduced by rota commitments, including periodic night shifts at Gartnavel covering medical wards, which are not directly relevant to orthopaedic training and results in lost training time.

ST: QUEH RDiT report uncertainty or lack confidence that they gain adequate experience, indicating that they may not achieve required outcomes. RDiT highlight difficulties completing workplace-based assessments and many struggling to achieve operative logbook requirements, particularly related to limited exposure to trauma and theatre experience. These concerns are linked to service pressures, reduced access to operative opportunities, theatre turnaround time and training culture issues. Concerns were raised regarding the continued allocation of RDiT to trainers who are perceived to provide a suboptimal training experience. Feedback suggested that training culture, rather than rota design, is the principal factor influencing training quality, and there were calls for greater scrutiny of trainer performance and accountability to ensure that RDiT consistently receive a beneficial educational experience.

Glasgow Royal Infirmary

Trainers: GRI advised that registrar-level RDiT generally achieve required procedural numbers. The middle-tier RDiT (F2/CT) are supported to gain experience in orthopaedics. This may be impacted by on-call and night commitments. F2 RDiT experience varies depending on individual career interests, with opportunities including an academic week which can be used for annual leave, taster week or theatre/outpatient experience. Overall, the balance of training opportunities is influenced by the number of RDiT within the department.

RDiT (All grades): At GRI, RDiT described a positive training environment with a strong culture of clinical training, good procedural exposure, and sufficient opportunities to achieve required operative case numbers. Access to theatre is largely limited to standard working days, amounting to approximately one to one and a half weeks of theatre activity every two months; however, RDiT felt this remained adequate for meeting training requirements. The rota structure, which does not routinely place ST as first on call, was viewed favourably as it facilitates greater engagement with educational opportunities compared with other sites in WOS. RDiT reported access to protected clinic and theatre time, alongside valuable experience managing referrals in the emergency department. Although dedicated development time is incorporated into the rota for FY doctors, RDiT reported that it is frequently utilised for annual or study leave, often at the department's encouragement, which can reduce exposure to clinical learning opportunities, particularly during scheduled clinic and theatre weeks.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Feedback from RAH indicates lower operative logbook volumes among RDiT, with some receiving ARCP Outcome 2; this is recognised as a cumulative issue across multiple placements rather than a significant deficit within a single post. The Training Programme Director is implementing measures to address this, including increasing opportunities in trauma theatres by doubling RDiT attendance where feasible, encouraging proactive attendance when not otherwise scheduled, and incorporating routine logbook review into trainees' educational supervision.

RDiT: F2 RDiT are ward based and have limited access to clinic and theatre experience, with attendance at theatre occurring only out of hours.

ST RDiT: RDiT reported adequate experience.

Royal Hospital Children Glasgow

No response was received from the site

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

Trainers: Not asked due to time constraints.

Queen Elizabeth University Hospital

RDiT: RDiT reported that although occasional reminders were required to ensure timely sign-off, assessors were approachable and willing to complete assessments. The spine team in particular was reported to be supportive of workplace-based assessments and educational discussions. However, opportunities to achieve procedural numbers can be difficult as noted previously limited.

Glasgow Royal Infirmary

FY RDiT: Challenges were identified in securing workplace-based assessment sign-offs, arranging supervisor meetings, and obtaining timely Educational Supervisor allocation. Engagement with workplace-based assessments was largely dependent on the person supervising.

ST: No issues were reported in obtaining workplace-based assessments.

Royal Alexandra Hospital/Inverclyde Royal Hospital

RDiT: No issues were reported in obtaining workplace-based assessments.

Royal Hospital Children Glasgow

ST: No issues were reported in obtaining workplace-based assessments, and RDiT felt their completion was actively encouraged.

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

This question was not asked, no issues were identified through the PVQ responses.

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

This question was not asked, no issues were identified through the PVQ responses.

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

Queen Elizabeth University Hospital

Trainers: QEUH highlighted that communication between trainers and RDiT is well established within Orthopaedics. While feedback is provided frequently, it is not always perceived by RDiT as formal

feedback. Foundation RDiT have regular contact with consultants and are encouraged to seek feedback, with structured opportunities for discussion and supervision throughout the working week. Foundation: RDiT reported receiving feedback primarily from FY2 colleagues.

CT/ST: RDiT advised of regular and immediate feedback through trauma meetings, particularly when presenting patient cases. These forums provide frequent opportunities for discussion and learning and RDiT were satisfied with feedback provided

Glasgow Royal Infirmary

Trainers: Trainers described a well-established feedback culture, including formal feedback through weekly trauma review meetings. Positive feedback is provided promptly, while developmental feedback is delivered privately and reflectively. Feedback from nursing staff is communicated through consultants and relayed to RDiT where appropriate. Trainers noted that providing feedback to Foundation RDiT can sometimes be more challenging than to more senior colleagues.

RDiT(All grades): Feedback was commonly received from CT RDiT and Clinical Fellows, RDiT were generally satisfied with this arrangement. Less feedback was received from registrars and consultants, which some felt reflected the clinical environment. However, one registrar was highlighted positively for providing valuable learning opportunities and constructive feedback. RDiT reported receiving feedback during on-call shifts, fracture clinics, and elective clinics. Opportunities to assess complex patients alongside consultants and review clinical findings were highlighted as valuable educational experiences.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Trainers: RAH trainers stated that feedback is provided regularly, including in daily trauma meetings, although RDiT may not always recognise when they are receiving feedback. Previous challenges relating to formal feedback processes were acknowledged. Trainers felt RDiT should take a proactive approach to seeking feedback and progressing learning opportunities.

Foundation: FY1 trainees reported that most portfolio feedback was provided by FY2 doctors and Clinical Fellows.

ST: RDiT reported good access to feedback through regular clinical meetings, including daily 5pm meetings, trauma meetings, and X-ray review meetings.

Royal Hospital Children Glasgow

RDiT described a positive learning environment within Orthopaedics, with feedback provided on the majority of cases. They reported being appropriately challenged regarding their clinical decision-making, which supported learning and development

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

Trainers: Not asked due to time constraints

Queen Elizabeth University Hospital

FY/CT/ST1&2 - GRI, RAH & QEUEH did not know of any formal mechanisms to feedback their training experience to trainers and management.

ST: RDiT described informal discussions regarding potential improvements within the department. However, some RDiT felt that when concerns were raised, they were expected to resolve the issues themselves.

Glasgow Royal Infirmary

FY/CT/ST1&2 - GRI, RAH & QEUEH did not know of any formal mechanisms to feedback their training experience to trainers and management.

Royal Alexandra Hospital/Inverclyde Royal Hospital

FY/CT/ST1&2 - GRI, RAH & QEUEH did not know of any formal mechanisms to feedback their training experience to trainers and management.

Royal Hospital Children Glasgow No response was received from the site

2.12 Culture & undermining (R3.3)

Queen Elizabeth University Hospital

Trainers: Trainers highlighted ongoing efforts to strengthen departmental culture and promote a sense of team cohesion among a large RDiT cohort. Following a deanery visit four years ago, RDiT identified concerns regarding team culture, the department has implemented a range of initiatives aimed at bringing RDiT together, including collaborative audit activities and wider group projects. Trainers expressed appreciation for the external 2025 survey data which had been shared with them

and led to this visit., They noted that the concerns raised have been taken seriously and have prompted a formal review process with significant associated actions. There is a strong focus on recognising and addressing inappropriate behaviours, with the majority of consultants having completed Active Bystander training. Trainers reported that awareness of professional behaviours and available support mechanisms has been incorporated into recent induction programmes. RDiT are routinely reminded of the multiple formal and informal routes available for raising concerns, including Educational Supervisors and other senior medical staff.

Foundation: RDiT described senior staff as generally supportive, with consultants frequently checking in informally regarding their wellbeing and training experience. However, RDiT reported having experienced some form of negative workplace interaction, largely attributed to a high-pressure working environment characterised by significant workload demands and widespread stress across the multidisciplinary team. RDiT described instances of strained interactions, disagreements between team members and challenges in collaborative working, particularly in relation to securing engagement from nursing colleagues with clinical decisions. While concerns were not attributed to specific individuals, RDiT felt there was a broader culture in which staff appeared fatigued and frustrations could affect day-to-day interactions.

CT/ST: RDiT reported feeling well supported by the orthopaedic team and stated that senior colleagues consistently supported their clinical decisions and wellbeing. While RDiT did not feel undermined by colleagues within the department, several described challenging interactions with other services, particularly the Emergency Department, where discussions could occasionally become confrontational or aggressive. Concerns were also raised regarding theatre culture, with some RDiT reporting experiences of theatre staff bypassing them and requesting to speak directly with senior/male colleagues. RDiT felt this behaviour was reflective of an established culture within the theatre environment rather than the actions of specific individuals. Female RDiT indicated that they experienced this more frequently, a perception that was also recognised by male colleagues. Although RDiT found these interactions difficult, they reported feeling uncomfortable challenging behaviours occurring within the clinical environment

Glasgow Royal Infirmary

Trainers: Trainers described a supportive departmental culture with trauma and review meetings organised on a team-based and subspecialty basis, fostering regular engagement between RDiT and senior staff. During induction, RDiT receive guidance on how to escalate both clinical and

professional concerns, with Educational Supervisors identified as the primary point of contact. Additional support is available through named senior trainers and Chief Residents, RDiT are also invited to attend consultant meetings. Trainers reported no awareness of culture or undermining concerns within the department itself. However, ongoing interdepartmental challenges, particularly involving interactions with the Emergency Department, were acknowledged. These issues have been escalated through Clinical Director channels, although progress remains dependent on engagement from the relevant services.

RDiT (all grades): RDiT described the orthopaedic team as highly supportive and reported positive relationships with consultants and senior colleagues. Concerns were raised regarding interactions with the Emergency Department, which some RDiT described as obstructive and at times inconsistent with expected professional behaviours. RDiT felt well supported by the orthopaedic team when such issues arose. RDiT described recent incidents involving verbal confrontation from a member of Emergency Department, advice was sought from supervisors, and appropriate support was given following the incident. However, RDiT were in agreement the experiences had negatively affected their confidence in returning to that clinical area

Royal Alexandra Hospital/Inverclyde Royal Hospital

Trainers: Trainers emphasised a clear commitment to maintaining a respectful and supportive working environment, with an expectation that inappropriate behaviour will not be tolerated. RDiT are encouraged to raise concerns with any member of the team, including Chief Residents. All consultants have completed Civility Saves Lives and Active Bystander training. Opportunities for engagement and feedback are provided through monthly audit and morbidity and mortality meetings, departmental teaching sessions and regular informal gatherings. Trainers noted that social activities, including consultant-funded events, help foster positive working relationships within the department. While concerns relating to behaviour and culture have previously been identified, trainers reported that these have been actively managed, with the Clinical Director leading investigations and follow-up discussions with those involved

Foundation: RDiT reported mixed experiences with senior support and departmental culture. Some felt that consultants were not always readily accessible and that concerns or disagreements regarding clinical decisions had occasionally been addressed in a manner which was perceived as not constructive. These experiences were described as relating to specific consultants rather than being representative of the department as a whole. RDiT advised that they had not formally raised these concerns. RDiT emphasised that the vast majority of consultants were supportive, approachable and

unlikely to undermine them, concerns were mainly associated with isolated interactions, particularly in the on-call setting.

ST: RDiT reported no concerns regarding support within the department and described consultants, specialty doctors and senior colleagues as approachable and accessible. Senior specialty doctors were highlighted in particular as providing valuable support and guidance in day-to-day clinical practice.

Royal Hospital Children Glasgow

ST: RDiT described a positive experience of departmental culture and reported feeling well supported by consultants and senior colleagues. No concerns regarding access to support or undermining behaviours were raised.

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

Trainers: Not asked due to time constraints.

Queen Elizabeth University Hospital

Foundation: RDiT raised significant concerns regarding workload, staffing levels and rota design. They felt that the rota was insufficiently staffed at FY1 level, resulting in increased workload and frequent periods of extended working with limited opportunity for recovery. Seven-day working stretches with minimal rest between shifts were highlighted as particularly challenging, with RDiT reporting high levels of stress and fatigue. Weekend on-call shifts were described as feeling unsafe at times due to workload intensity and staffing pressures. Although attempts had been made to facilitate protected breaks, RDiT felt that these measures were not effective in practice and reported difficulties accessing breaks during busy shifts. RDiT stated that there was no clear mechanism for escalating concerns when breaks could not be taken, noting that more senior RDiT were often similarly unable to access rest periods. While registrars were perceived as supportive, their clinical commitments often limited their availability. RDiT expressed frustration that persistent staffing and workload issues were difficult to escalate formally and felt that repeated exception reporting or Datix submissions were not a practical solution to ongoing systemic pressures.

CT/ST: RDiT acknowledged that the rota includes a greater number of night shifts than some other placements but generally viewed this as an expected component of working on an on-call rota. RDiT

reflected on changes to rota design over recent years, noting that additional staffing arrangements introduced to support junior trainees had altered the distribution of duties across the team. The increased clinical support provided to the ward based Foundation RDiT has reduced opportunities for more CT/ST RDiT to undertake activities that would ordinarily contribute to their own training and development.

Glasgow Royal Infirmary

RDiT (All grades): RDiT reported concerns regarding staffing levels, workload and the impact of rota gaps on service delivery. The rota was described as comparatively stretched, resulting in frequent night shifts and periods of extended working patterns, including seven consecutive days followed by a single recovery day. While recognising night work as an expected aspect of the role, RDiT felt that the frequency of shifts and overall workload could have a negative impact on wellbeing.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Foundation: RDiT described workload as variable, with some periods being manageable while others were significantly more challenging. While workload pressures were not constant, periods of high demand could have a considerable impact on the working day and trainee wellbeing.

Royal Hospital Children Glasgow

ST: RDiT reported concerns regarding the rota structure, particularly the high proportion of time spent undertaking on-call duties. Workload during night shifts was very manageable and the impact of the full shift pattern on T&O training is significant and reduced opportunities for meaningful training. Some RDiT estimated that the majority of their placement was spent undertaking on-call duties, which limited opportunities for learning, progression and clinical development. This was described as demoralising, with some trainees feeling that concerns they had raised regarding the training experience were not adequately heard or acted upon. RDiT felt the rota required review to achieve a more appropriate balance between service provision and training opportunities.

All Sites: Concerns were raised regarding the use of 12-month rolling rotas for RDiT undertaking six-month placements. RDiT identified that this leads to an uneven distribution of training opportunities, with some placements becoming disproportionately on-call heavy while others

benefited from greater access to elective work and training lists. As a result, RDiT perceived the quality of their experience to be influenced by where they entered the rota cycle, creating a lack of equity and inconsistency in training exposure across placements.

2.14 Handover (R1.14)

Queen Elizabeth University Hospital

Trainers: QEUH: Trainers acknowledged the challenges associated with coordinating handover processes within a large department containing numerous RDiT and clinical teams. The morning trauma meeting represents a substantial multidisciplinary exercise involving consultants and RDiT, while Foundation RDiT undertake a separate handover focused on ward-based issues. An additional handover occurs at 5pm, allowing Foundation RDiT to transfer responsibility to the evening team. While trainers recognised the complexities associated with managing multiple handovers that may discuss overlapping clinical issues, they felt the current arrangements were as robust as possible. The designated ward consultant role was highlighted as an important mechanism for maintaining continuity and ensuring communication between the parallel handover processes.

Foundation: RDiT described a structured handover process between Foundation doctors, with dedicated handovers taking place in the morning following the night shift and at both 5pm and 8pm. The process was generally viewed as effective, with RDiT reporting that communication between teams worked well and that they felt clear about escalation pathways and who to contact when concerns arose. The ward consultant does not attend handover.

CT & ST: RDiT reported that formal handover processes function effectively, with a structured handover taking place at 8pm when the night registrar assumes responsibility. Handover discussions cover all new admissions and outstanding overnight issues, and RDiT felt that the process provides comprehensive transfer of information, clear escalation pathways and supports patient safety.

Trauma meetings were viewed as an important component of communication within the department, some RDiT commented that feedback received during these meetings was occasionally unhelpful, although concerns were attributed to interactions with other specialties rather than the orthopaedic department itself. Concerns were raised regarding cross-site responsibilities, particularly for registrars providing cover between sites. RDiT described the situation where attendance at handover was followed by travel to Gartnavel during peak traffic periods, resulting in missed training opportunities, including one-to-one educational meetings.

Glasgow Royal Infirmary

Trainers: Trainers reported that handover processes are well established and protected within the daily workflow. A dedicated morning handover, lasting up to one hour, provides an opportunity for detailed discussion of inpatients and any unwell patients requiring ongoing attention. A further handover takes place later in the day. Trainers considered these arrangements to be robust and effective in supporting safe patient management and communication between teams.

RDiT (All grades): RDiT reported that handover arrangements within the department function effectively and support safe continuity of patient care. End-of-day and overnight handovers were viewed positively, with staff remaining on duty until 8.30pm to ensure ongoing cover and appropriate transfer of information. While there is no formal morning handover process for Foundation doctors, RDiT felt that this does not significantly impact patient management, as few clinical issues require formal handover between shifts and day-to-day care is supported through individual job lists. The trauma meeting was highlighted as a key patient safety mechanism, providing a structured forum for reviewing and discussing all patients and reducing the risk of important issues being overlooked. Communication across the multidisciplinary team was considered effective, with RDiT kept informed throughout the day and relevant matters escalated or handed over as required. Overall, RDiT expressed confidence in the department's handover, communication and escalation processes, and felt that patient safety concerns would be appropriately identified and addressed.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Trainers: Trainers described significant efforts to strengthen handover arrangements within the department. Morning trauma meetings provide a formal forum for clinical discussion, while an additional multidisciplinary meeting takes place at 5pm with the wider team present. Protected time is allocated to enable RDiT to hand over to evening colleagues effectively. With an anticipated increase in the number of resident doctors from August, the department has introduced a staggered changeover process to further protect handover time and ensure continuity of patient care.

RDiT (All grades): RDiT reported a structured handover process with multiple opportunities for communication throughout the day. A formal handover meeting takes place at 5pm, attended by both on-call consultants, ensuring senior oversight of patient management and outstanding issues. A further junior-to-junior handover occurs at 8.30pm and was described as functioning effectively without requiring routine registrar involvement. Morning meetings also provide an additional opportunity to review patients and maintain continuity of care across shifts.

Royal Hospital Children Glasgow

No response was received from the site

2.15 Educational Resources (R1.19)

Trainers: Not asked due to time constraints

All Sites ST: RDiT highlighted simulation-based training as a particular strength of the training programme. Simulation delivered through the University of Glasgow was described as being of a high quality and was regarded as one of the most effective learning methods available.

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.

Queen Elizabeth University Hospital

Foundation: While RDiT were not familiar with formal wellbeing support mechanisms, they felt comfortable approaching their Clinical or Educational Supervisor. Senior staff were described as supportive and approachable, and RDiT were confident that concerns would be taken seriously. The consultant responsible for the FY1 rota was highlighted as taking a particular interest in RDiT wellbeing.

CT/ST: RDiT reported that they would approach their Clinical or Educational Supervisor if they required support and were confident they would be directed to the appropriate services or individuals for further assistance.

Glasgow Royal Infirmary

RDiT (All grades): RDiT were less familiar with formal support pathways but identified their Educational Supervisor as their main contact should concerns arise and felt reassured that appropriate action would be taken.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Foundation: RDiT felt confident that any personal or professional concerns would be addressed appropriately and that they would be supported, including through time away from work, if required. ST: RDiT reported that they had not personally required additional support but felt confident that it would be available if needed. The TPD was described as approachable and supportive, supervisors were viewed as willing to provide assistance

Royal Hospital Children Glasgow

ST: RDiT reported that they had not personally required additional support but felt confident that it would be available if needed.

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

This question was not asked, no issues were identified through the PVQ responses

2.18 Raising concerns (R1.1, 2.7)

Queen Elizabeth University Hospital

Trainers: Trainers reported that escalation pathways are clearly outlined within the induction booklet through a dedicated escalation flow diagram.

Foundation: RDiT reported that concerns could be escalated to orthopaedic registrars and consultants as required. Although none had needed to do so personally, they felt clear escalation routes were available if concerns arose.

ST: RDiT reported a recent patient safety concern was received positively and taken seriously by consultants. RDiT expressed confidence in local escalation processes and the willingness of senior staff to respond to concerns.

Glasgow Royal Infirmary

Trainers: Trainers described a clear escalation structure within the department, ensuring that no RDiT is without access to senior support. Escalation pathways are covered during induction, with clear routes from Foundation level through to registrar and consultant grades. RDiT are able to contact the consultant on call at any time if required, and consultants will support concerns directly when the usual clinical team is unavailable.

RDiT (All grades): RDiT reported feeling comfortable raising concerns through the Datix system and discussing issues with the multi-disciplinary team and that patient safety concerns would be taken seriously and managed appropriately if raised. This view was shared across all sites, with RDiT expressing confidence in local escalation processes and the willingness of senior staff to respond to concerns.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Trainers: RAH: Trainers reported that RDiT are encouraged to raise concerns with their supervisor at the earliest opportunity. Induction includes guidance on the use of the DATIX reporting system, and trainees are encouraged to attend Morbidity & Mortality meetings.

Foundation: RDiT reported clear escalation pathways, with registrars readily available for support.

Concerns could be escalated to the medical team, senior charge nurse or through the Datix system.

ST: RDiT felt that patient safety concerns would be taken seriously and managed appropriately if raised. This view was shared across all sites, with RDiT expressing confidence in local escalation processes and the willingness of senior staff to respond to concerns.

Royal Hospital Children Glasgow

ST: RDiT felt that patient safety concerns would be taken seriously and managed appropriately if raised. This view was shared across all sites, with RDiT expressing confidence in local escalation processes and the willingness of senior staff to respond to concerns.

2.19 Patient safety (R1.2)

Trainers: Not asked due to time constraints

Queen Elizabeth University Hospital

Foundation: RDiT raised a number of patient safety concerns, largely relating to workload pressures, staffing levels and continuity of care. They reported that the volume of work and limited staffing frequently result in delays to the important but not critical clinical tasks. They see a link from this to less efficient patient care with examples given of delayed discharge or delay in a patient reaching theatre as not all elements of care had been able to be completed effectively. They see this level of impact on a daily basis. Additionally, they note less senior oversight of medically complex patients

and post-operative complications. Frequent changes in ward round leadership were felt to impact continuity, occasionally leading to confusion regarding management plans and outstanding investigations. Concerns were also raised regarding nursing staffing pressures, which RDiT recognise contribute to missed or delayed medication administration and challenges in escalating deteriorating patients. RDiT described feeling responsible for managing a significant proportion of ward-based medical issues, often under considerable time pressure, and felt that delays to important jobs have implications for patient care.

CT/ST: RDiT expressed confidence in the standard of care delivered, although some noted that waiting times for treatment could be a concern, often related to delays awaiting investigations and imaging.

Glasgow Royal Infirmary

RDiT (All grades): RDiT reported concerns primarily relating to the management of patients' medical needs rather than orthopaedic care. They noted that routine consultant-led review of established inpatients was limited, with ward rounds focusing mainly on new admissions. As a result, some patients could remain on the ward for extended periods without senior review, with junior RDiT often responsible for monitoring blood results and identifying issues requiring escalation. RDiT highlighted challenges relating to the management of complex medical conditions, including diabetes, and felt there was significant reliance on support from the Care of the Elderly team for comprehensive medical review. While this support was valued, RDiT expressed concern that delays in specialist review could impact patient care.

RDiT additionally noted that patients with delirium can present particular challenges, especially during periods of staff shortage, although they acknowledged the significant nursing presence on night shifts. A number of RDiT indicated that they no concerns in the quality or safety of orthopaedic care provided.

Royal Alexandra Hospital/Inverclyde Royal Hospital

Foundation: RDiT highlighted that many orthopaedic patients have significant medical co-morbidities which can require input from more senior clinicians. While escalation pathways were available, RDiT felt that obtaining senior medical review could sometimes take time.

ST: RDiT expressed confidence in the standard of care delivered, although some noted that waiting times for treatment could be a concern.

Royal Hospital Children Glasgow

ST: RDiT at RHCG reported no concerns regarding the quality or safety of care provided.

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

Trainers: Not asked due to time constraints

Foundation: Not asked due to time constraints.

Queen Elizabeth University Hospital

CT/ST: Some RDiT reported no personal involvement in a serious patient safety incident and felt confident that, if such an event occurred, they would receive support from fellow RDiT, consultants and supervisors throughout the process. It was noted that some RDiT were reluctant to provide a response to this question.

This mixed response suggests not all RDiT were comfortable they would be supported but no specific incidents were shared.

Glasgow Royal Infirmary

CT/ST: RDiT felt that they would be well supported by colleagues and senior staff should they become involved in a significant patient safety incident.

Royal Alexandra Hospital/Inverclyde Royal Hospital

ST: RDiT reported no concerns regarding how patient safety incidents would be managed and felt confident that appropriate support would be available.

Royal Hospital Children Glasgow

RDiT reported no concerns regarding the handling of patient safety issues.

2.21 Other

Overall Satisfaction Scores: n/a.

RDiT report positive trainer–trainee relationships and value the flexibility to be self-directed in selecting trainers to meet specific learning needs. However, concerns were raised by a number of

RDiT that those with knowledge of individual trainers can select posts and trainers for extended periods that give them the best training opportunity. The allocation of individual RDiT to trainers is not transparent and there is not a recognised process that provides equity of opportunity over the programme. This is a particular issue for RDiT who are new to the region. It was suggested that a more balanced and transparent allocation of training opportunities would improve equity across the programme.

3. Summary

Is a revisit required?	Yes	No	Dependent on outcome of action plan review
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The panel commended the engagement of the sites and medical education team in supporting the visit and noted the considerable efforts being made to improve training and culture.

Positive aspects of the visit:

- Excellent engagement from the Medical Education team and site management team in supporting the visit.
- RDiT across QEUH, GRI, RAH/IRH and RHCG reported positive experiences of formal supervision, with appropriate guidance and support available.
- The Training Programme Director was consistently described as flexible, engaged and supportive.
- All sites described senior staff and consultants as approachable, accessible and supportive.
- RDiT across all sites demonstrated a clear understanding of escalation pathways and processes for managing patient safety concerns.
- The training environment and procedural exposure available within GRI were highly valued by ST RDiT.
- All RDiT provided positive examples of receiving constructive feedback to support their development.
- Simulation training delivered by the University of Glasgow was identified as a highlight of the training programme.
- The handover process was generally reported to be operating well across all sites

- RDiT across most sites were aware of available support mechanisms and felt confident they would receive appropriate assistance if required.

Less positive aspects of the visit:

- Concerns were raised at FY level within QEUH regarding workload intensity and rota design, with reports of missed breaks and weekend on-call shifts feeling highly pressurised.
- Potential patient safety concerns were raised by FY RDiT in relation to workload pressures, staffing levels, continuity of care, delays in clinical tasks and escalation processes. While this was felt most acutely at QEUH, GRI and RAH also reported similar concerns specifically around delay of patient reviews.
- A lack of a structured and consistent formal teaching programme was highlighted at both QEUH and GRI. While a more established teaching programme was reported at RAH/IRH, attendance was frequently impacted by clinical workload and service demands.
- Access to the appropriate numbers of surgical cases at the correct level to meet ISCP requirements is a major concern for Surgical RDiT in QEUH and RAH/IRH. The reasons vary by site but include rota design, workflow and trainer engagement.
- At RHCG, the balance between service provision and training was reported to be suboptimal, with extensive on-call commitments reducing training opportunities and negatively impacting trainee morale
- RDiT in QEUH, GRI and RAH/IRH were uncertain about the mechanisms available for providing feedback to senior staff and departmental management.
- RDiT at QEUH and GRI described challenges in interdepartmental working relationships with the Emergency Department, with some reporting confrontational interactions that had adversely affected their wellbeing and working experience.
- RDiT at QEUH reported behaviours within the theatre multidisciplinary team that were perceived as demonstrating undermining and showing gender bias.
- RDiT at QEUH have variable confidence in relation to support they would receive in the event of an adverse incident.
- Variability in access to training opportunities across the programme is perceived to have an impact on learning experiences and career development. RDiT do not have confidence that action will be taken when they raise these concerns

4. Areas of Good Practice

Ref	Item	Action
4.1	A well-established and effective feedback model was evident across all sites, facilitating ongoing development and trainee engagement, particularly through trauma review meetings.	n/a
4.2	The strong clinical training culture and breadth of procedural exposure available within Glasgow Royal Infirmary was commended by Surgical RDiT.	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	Induction materials should ensure clear understanding on how to use the rota and how to contact the relevant orthopaedic registrar at RAH/IRH.	n/a
5.2	The timings of the early morning teaching at the RHCG should be reviewed to ensure inclusivity of all surgical RDiT.	n/a

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	Medical staffing must be reviewed to ensure doctors in training have a reasonable and manageable workload that supports safe and effective patient care. (QEUH, GRI, RAH & IRH)		FY
6.2	Rota patterns must support RDiT who are working across sites.(QEUH)		CT/ST1-2
6.3	There must be a protected formal departmental teaching programme for doctors in training (QEUH, GRI, RAH/IRH)		All grades
6.4	RDiT must have access to the appropriate procedural opportunities to enable them to meet the requirements of the curriculum and to achieve satisfactory ARCP outcomes. (QEUH & RAH/IRH)		CT/ST
6.5	The department must review the rota structure and night shift allocation to ensure that daytime sub-specialty training is not compromised. (RHCG)		All grades
6.6	Relationships at the Emergency Medicine – T&O interface must be improved. (QEUH & GRI)		All grades
6.7	The learning environment for RDiT must be supportive and inclusive (QEUH)		All grades
6.8	All RDITs must have equitable access to the same training opportunities and educational time with trainers to promote a more consistent training experience. (All sites).		All grades