Public Services Delivery Scotland NHS SCOTLAND

SCOTLAND DEANERY QUALITY MANAGEMENT: VISIT REPORT

Date of visit	4th June 2026	**Level(s)**	Foundation, Core, Specialty
Type of visit	Enhanced Monitoring Visit (in-person)	**Hospital**	Borders General Hospital
Specialty(s)	General Surgery	**Board**	NHS Borders

Visit Panel	
Mr Alastair Murray	Visit Chair - Deputy Postgraduate Dean
Dr Fiona Drimmie	Associate Postgraduate Dean (Quality)
Mr Brian Stewart	Associate Postgraduate Dean (Quality)
Dr Calum McDonald	Training Programme Director
Ms Kate Bowden	Education QA Programme Manager (General Medical Council)
Mr Niall Macintosh	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Ashley Bairstow-Gay	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Foundation, Surgery
Lead Dean/Director	Dr Greg Jones
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	5
Resident Doctors in attendance	6 (4-FY1, 1-Core, 1-ST)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	1	Medical Director	1	Other	15

Report approved by Lead Visitor / Lead Dean	Mr Alastair Murray Dr Greg Jones

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.

General Surgery at Borders General Hospital has been under the GMC Enhanced Monitoring process since August 2025. The last visit took place on 15th July 2025. At this visit the panel commended the engagement of the site and medical education team in supporting the visit whilst noting serious concerns regarding support, patient safety and wellbeing.

The visit identified 9 requirements, 8 of which remain open:

Ref	Issue	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.	FY1
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.	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.	FY1
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.	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.	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	FY1

	of their curriculum.	
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.	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.	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. (CLOSED 23rd April 2026)	FY1

There are currently 4 requirements attached to the Enhanced Monitoring case which are:

- R1.1 - Organisations must demonstrate a culture that allows learners and educators to raise concerns about patient safety, and the standard of care or of education and training, openly and safely without fear of adverse consequences.
- R1.7 - Organisations must make sure there are enough staff members who are suitably qualified, so that learners have appropriate clinical supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, while creating the required learning opportunities.
- R2.7 - Organisations must have a system for raising concerns about education and training within the organisation. They must investigate and respond when such concerns are raised, and this must involve feedback to the individuals who raised the concerns.
- R3.3 - Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.

NTS Survey Data (2025):

All Trainee General Surgery – Red Flags – overall satisfaction, supportive environment. Pink Flags – adequate experience, clinical supervision, clinical supervision out of hours, educational supervision, feedback, reporting systems.

Core / ST – All Grey Flags.

FY1 Surgery – Red Flags – adequate experience, clinical supervision, feedback, overall satisfaction, reporting systems, supportive environment. Pink Flags – clinical supervision out of hours, educational supervision.

STS Survey Data (June 2025):

Bottom 2%.

All Trainee – Red Flags – discrimination, equality & inclusivity, induction. Pink Flags – clinical supervision, educational environment & teaching, handover.

Foundation – Red Flags – discrimination, equality & inclusivity. Pink Flag – induction.

ST – All Grey Flags.

STS Survey Data (January 2026):

All Trainee – Green Flag – rest facilities.

Foundation – Green Flag – rest facilities.

Core – All Grey Flags.

The report includes feedback received prior to the visit from specialty doctors with a recognised trainer role who are currently providing formal supervision for resident doctors in training (RDITs) and additionally feedback received in the pre-visit questionnaire.

Department Presentation:

The visit commenced with Mr Martin Berlansky, Clinical Director delivering an informative presentation to the panel. This focused on key priorities which were noted as culture, safety, escalation, consistency and adoption of the TBQR pilot. It also covered progress made to date including recent resident doctor feedback, challenges and plans going forward.

2.1 Induction (R1.13):

Trainers: Trainers reported that FY1s in block 1 receive a shadowing week prior to commencing in post including time on the ward which they believe prepares FY1s well to work in the department. Block 2 FY1s largely rotate in from Edinburgh and can find it difficult to settle into the department, they receive hospital and surgical induction. Two specialty doctors have recently taken on the roles of Foundation champion and wellbeing champion. They actively participate in departmental inductions with positive feedback received across the training year. All FY1s are e-mailed the rota along with the

induction booklet prior to commencing in post which contains tips and tricks from previous FY1s and is updated regularly throughout the year. Specialty doctors are also actively involved in CT/ST inductions however there is no written material or handbook for these cohorts. Individual inductions are arranged for those who cannot attend the main induction session.

FY1/CT/ST: RDITs reported receiving good quality hospital induction which worked well. FY1s confirmed receiving departmental induction. CT/ST felt there was robust departmental induction in August which is incorporated with other specialities however noted no formal planned induction in February. It was suggested that information on absence reporting would be useful along with a handbook for CT/ST including details of on-call, roles and responsibilities in the Emergency Department. They also suggested that there should be a formal induction in February which should include a tour, meet the team and walk through of systems used in the health board which would be particularly useful for someone coming from a different health board or with no previous experience of working in Borders General Hospital.

Nurse/AHP: The team are aware of induction taking place and welcoming the team to the department.

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

Trainers: Trainers reported that a specialty doctor has taken on the role of rota co-ordinator and education lead and they are responsible for publishing the departmental teaching programme. This consists of 2 afternoon sessions per month with no elective activity scheduled to support attendance. There are also a variety of informal teaching sessions that take place regularly. FY1s are asked to present at meetings however recent uptake has been minimal. They noted no problems in the middle tier being able to attend their regional teaching.

FY1CT/ST: FY1s reported receiving one hour of regional teaching per week, 30 minutes of departmental teaching weekly and 2-3 hours of monthly departmental teaching which they can easily attend. CT/ST confirmed receiving 2 hours of monthly departmental teaching which incorporates the ST providing a teaching session to the FY1s/CT. On call commitments were noted as preventing attendance at regional. They advised on being able to attend around half of the planned regional teaching sessions. Issues with Wi-Fi were also noted and difficulties in accessing recordings within

the hospital with most having to catch-up at home. It was felt that sharing the responsibility for providing teaching to FY1s/CT with specialty doctors would be useful and helpful. Finally, there are weekly morbidity and mortality meetings (M&M) which provide variable opportunities for discussion and teaching.

Nurse/AHP: The team advised that they hold bleeps to allow RDITs to attend teaching sessions.

2.3 Study Leave (R3.12)

Trainers: Trainers reported no challenges in supporting study leave requests which they try to accommodate. They are not aware of any issues in requests being declined.

CT/ST: RDITs reported no problems in requesting or taking study leave.

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

Trainers: Trainers reported that the medical education team provide the clinical director with details of each RDIT cohort, they are then allocated evenly across recognised trainers. They noted that they have time in their job plans for supervisory roles and work flexible rotas to fulfil theatre lists. Transfer of information forms relating to RDITs with known concerns are shared with the clinical director who disseminates to the appropriate trainers. They noted good working relationships with the Training Programme Director for General Surgery (TPD).

FY1/CT/ST: RDITs reported meeting their educational supervisors formally 2-3 times per block which they find useful and supportive.

Nurse/AHP: The team are aware that RDITs are allocated to a supervisor who they can contact for support. In general, they are not aware of any issues with RDITs accessing senior support.

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 there are clear escalation pathways for clinical supervision during the day and out of hours which are highlighted at induction, within the induction handbook and clarified in

morning handovers daily. They advised of small changes to the rota and support structure which have been implemented since the last visit along and that all RDITs are now included in all handovers. There has also been a ward support role developed. This is generally a clinical development fellow (CDF) who provides an additional layer of support for FY1s. Escalation pathways were described as FY1 - middle tier on-call/clinical support doctor – consultant on-call. They noted a future aspiration for the department would be to have all information readily available within an app. They advised of a recent instance regarding support where RDITs felt they had to cope with problems beyond their level of competence however these concerns were not escalated appropriately. This was discussed with consultants and the Medical Director; the matter was addressed and learning taken. The importance of following escalation pathways was reiterated and there was agreement that consultants should be more visible. They confirmed that RDITs only seek consent for procedures they are competent to undertake and that consultant support is always available.

FY1/CT/ST: RDITs confirmed being aware of who to contact for clinical supervision both during the day and out of hours with accessible and approachable seniors despite awareness of interpersonal issues. On call arrangements and escalation pathways are clear and confirmed within morning handovers. FY1s commented that although there is a ward support doctor regularly allocated, they are not generally visible on the ward however are easily accessible and provide a useful additional layer of support for complex cases. RDITs confirmed that in general they have not had to cope with problems beyond their level of competence. Challenges were noted with the rota, staffing and gaps in the rota particularly relating to appropriate cover and available support for Urology which is an area cross covered by the middle tier and can leave them feeling exposed when not covered by a consultant. Patient safety concerns have been raised regarding appropriate levels of support for Urology patients and delays to patient care. Examples were provided and detailed as significant delay in a patient receiving treatment and patient review without sufficient checking of notes resulting in subsequent changes to the management plan.

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

Trainers: Trainers reported that they have had refresher training on all curricula since the last visit. They noted that clinic uptake has declined slightly and noted difficulties with new software used for booking rooms in clinic which can display incorrect room availability. Theatre sessions are allocated on a weekly basis and take into consideration the training needs of CT/ST. They believe that RDITs

are provided with a good range of cases and opportunities to attend theatre and noted a move in reducing theatre sessions for specialty doctors to help accommodate the training needs of CT/ST where necessary. They also noted dedicated theatre lists for upper GI endoscopy and minor lesions. FY1s are also allocated float days where they can attend theatre or clinic sessions of interest. This is facilitated by a rota redesign and additional FY1 numbers however there are further change to the rota scheduled for FY1s in August 2026 which will include H@N cover. This is believed to be a risk to overall satisfaction of Foundation training. They change will see 3 FY1s available during the day and the float FY1 used to help cover annual leave. The pros of these changes are experience in H@N and managing unwell patients. The cons are less flexibility to take annual leave at desired times and less flexibility for training opportunities. Changes will be monitored to ensure training is not impacted. Trainers are not aware of any competencies or learning outcomes that would be difficult for RDITs to obtain when in post.

FY1/CT/ST: RDITs stated that the post has allowed them to develop skills and competence in managing acutely unwell patients. FY1s noted having the opportunity to be involved in procedures which are very well supported by the middle tier. CT/ST have good access to clinics and theatre sessions and noted a particular strength in the rota in the way elective cases are carefully thought out. FY1s believe there is a good balance between non-educational tasks, training and education which has been helped by the increase to FY1 numbers. They also commented on receiving allocated float weeks in the rota to attend teaching, clinics or theatre session of interest.

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

Trainers: Trainers commented that it can depend on the RDIT as to whether they achieve all required portfolio assessments and believe they are provided with good training opportunities.

FY1/CT/ST: RDITs noted no difficulties in obtaining required competence, intended learning outcomes or workplace-based assessments in post. FY1s commented on being provided with opportunities to lead and receive assessments and feel well supported. CT/ST noted some resistance from consultants in allowing them to participate in surgeries towards the start of the post however understand this can be part of consultants getting to know your skill set.

Nurse/AHP: The team confirmed contributing to FY1 Team Assessment of Behaviour (TABs).

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

Trainers/CT/ST: Not asked due to time constraints.

FY1: RDITs noted no opportunities to learn with other health professionals in the team.

Nurse/AHP: AHPs reported providing simulation training with RDITs which is a new development with 2 sessions having taken place.

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

Trainers: Trainers reported that RDITs are well supported in undertaking quality improvement and audit projects with RDITs given the opportunity to present on a Tuesday. They also noted a QI academy recently started by the clinical governance team, which takes place over 6 morning sessions.

FY1: RDITs reported good opportunities to be involved with and present quality improvement projects and audits in the department.

CT/ST: Not asked due to time constraints.

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

Trainers: Trainers stated that feedback is provided throughout the day, they noted the importance of establishing understanding from the beginning which enables conversation and learning. They noted providing formal feedback through assessments and that RDITs are given the opportunity to present cases within meetings which again leads to discussion and learning. It has been reported that the delivery of feedback from some trainers to CT/ST has been perceived as poor while other reports are positive.

FY1/CT/ST: RDITs reported being provided with regular feedback in morning handover where there are opportunities to discuss patients from the previous day. FY1s are also provided with ongoing

informal feedback throughout the day which is constructive and meaningful. CT/ST reported rarely receiving direct feedback day to day unless sought.

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

Trainers: Trainers reported that following the last visit the medical education team held weekly meetings to provide support and gather feedback from RDITs on the quality of their training. At the request of RDITs these meetings were moved to fortnightly and now take place monthly. Mr Berlansky, Clinical Director also presents feedback from FY1s within the Tuesday departmental meeting, a summary of discussions and actions is compiled and circulated to all. RDITs are also aware that concerns can also be raised with supervisors, the medical education team or the medical director.

FY1/CT/ST: FY1s reported being invited to attend a monthly meeting with Mr Berlansky, Clinical Director at which they can provide feedback on the quality of training they are experiencing. Although they have provided feedback in this meeting, they can find it intimidating to do so. A note of the meeting is taken and circulated to all. In addition, there is a monthly RDIT forum run by the chief residents, which they believe is useful and provides a safe space. RDITs also reported a reluctance on occasion to raise concerns due to worries that doing so may have repercussions and negatively affect their training, they are however aware that any concerns can be escalated to the Director of Medical Education, Medical Director or Associate Medical Director and feel comfortable in doing so.

2.12 Culture & undermining (R3.3)

Trainers: Trainers stated that improving the team culture in the department is a work in progress however they have seen improvements over the last year. They acknowledge and recognise that there may always be issues to resolve however people are more aware and regularly check-in to ensure others are not impacted especially RDITs. Working relationships between consultants and the middle tier still has challenges and efforts are being made to listen and not interrupt however there can be occasions when people talk over each other which can be perceived by others as shouting. There is awareness and they believe progress is being made. They noted being part of the TBQR pilot which they believe is making some impact. RDITs are encouraged to raise any concerns

regarding bullying and undermining which is also covered within induction and includes how to escalate concerns.

FY1/CT/ST: RDITs reported a supportive clinical team. Most have not experienced behaviours of bullying or undermining however a specific instance of bullying and undermining was disclosed which was discussed with the Medical Director, Associate Medical Director and Director of Medical Education directly after the visit. RDITs reported witnessing behaviours of bullying and undermining on occasion and stressed this is not a day-to-day experience and behaviours are not generally directed at RDITs. Examples were provided of offhand misogynistic comments, undermining within morning handover and department meetings, and that M&M meetings and ward rounds can often feel tense and uncomfortable as people do not speak graciously to each other, this behaviour tends to be between consultants and specialty doctors. They are aware of significant problems regarding team culture in the department which has Medical Director involvement however stated that the culture has not affected training.

Nurse/AHP: The team reported that guidance on bullying and undermining is available on the intranet. They are not aware of any instances where RDITs have been subject to behaviours of bullying or undermining.

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

Trainers: Trainers stated that the rota can be reliant on locums however at present is full. The FY1 rota is compliant and monitored. The CT/ST rota has had some redesign, and there have been reports of high on call burden with low down time. There has been expansion to FY1 numbers which they believe has helped balance the workload.

FY1/CT/ST: RDITs reported no gaps in the rota other than from short term sickness. FY1s believe the increase in FY1s due to Foundation Programme expansion has helped balance the workload and provides good peer support. They noted one shift pattern as being particularly hard, normal days Monday-Wednesday into long days Thursday and Friday into short days Saturday and Sunday with one day off on the Monday. CT/ST raised concerns regarding the on call rota and weekly allocation of duties. The on call rota is only released one month at a time and the elective rota agreed on a Friday for the coming week. They believe this is due to brinksmanship of those working on the middle tier rota with examples provided of poor communication, requests not going through appropriate channels and last-minute changes/swaps by specialty doctors and consultants to clinics, on call, annual leave and study leave which are rarely communicated to the rota co-ordinator. They believe the rota co-

ordinator is working the rota to the best of their ability and appreciate efforts made. They also noted that some colleagues are rarely present in the hospital on administrative days which has been raised with the medical director.

2.14 Handover (R1.14)

Trainers: Trainers advised that handover arrangements provide safe continuity of care for new admissions and downstream wards. They described a morning board round prior to the morning ward round and noted that all RDITs are invited to attend all handovers. On call arrangements are reiterated within morning handovers.

FY1: FY1s reported that handovers are structured and provide safe continuity of care for patients and new admissions**.** All patients are reviewed at morning handover and there are opportunities for discussion and learning.

CT/ST: Not asked due to time constraints.

Nurse/AHP: The team are confident handover is effective in ensuring information relating to sick patients is shared.

2.15 Educational Resources (R1.19)

Trainers: Trainers recognise day to day challenges with space which has been adjusted as much as possible for the building. There is a library and seminar room onsite. There is also a sim lab which is easily accessible for all and a skills club which is very well attended. RDITs have online access to short surgical notes which can be helpful however they are unsure how widely this is used. New laptops have also been purchased.

FY1: FY1s reported limited office space and computers available to them.

CT/ST: Not asked due to time constraints.

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.

FY1: FY1s stated that are aware of who to contact should they be struggling with any aspects of the job or their health.

CT/ST: Not asked due to time constraints.

Nurse/AHP: The team reported that they would follow escalation pathways if patient safety concerns were raised.

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/FY1/CT/ST: Incorporated in section 2.11.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers commented that RDITs are encouraged to speak to their educational supervisors, the clinical director or medical director if they have any patient safety concerns or concerns with their training and education. Escalation pathways are covered as part of induction and there is a designated wellness champion who can also be contacted.

FY1: FY1s are confident that any concerns raised regarding patient safety would be addressed promptly. They are happy to raise concerns and find middle grades approachable.

CT/ST: Not asked due to time constraints.

2.19 Patient safety (R1.2)

Trainers: Trainers believe that they provide a safe consultant lead service. Regular check-ups have been established to ensure clinical safety, and all are encouraged to formally record any instances or near misses.

FY1/CT/ST: RDITs stated they would have no concerns if a friend or family member were to be admitted to General Surgery unless it was towards the end of a consultants busy 7-day on call. They also noted concerns with Urology due insufficient cover and perceived delays in patient care. FY1s commented that all surgical patients being boarded out with the ward is rare however on occasion where this happens these patients are discussed at morning handover. Patients from Medicine, Gynaecology and Orthopaedics boarded to the surgical ward are not discussed within handover. Although FY1s are aware of escalation pathways for deteriorating patients and that they are responsible for undertaking tasks for patients boarded to the surgical ward there can be a lack of communication and a preference for Medicine and Gynaecology to undertake their own reviews and task for their patients, they system for Orthopaedics is unclear.

Nurse/AHP: The team believe that the department provides a safe environment for patients. They described daily hospital safety briefings each morning where any safety concerns would be raised, FY1s are invited to attend. There is also a board round in ward 7 every day. They noted that ward rounds take place at the same time every day which can be challenging for FY1s to attend however they are welcome if time allows.

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

Trainers: Trainers reported that adverse incidents are reported through the IN Phase system, previously these would have been recorded through the datix reporting system. They highlighted that a large number of SAERs remain open. There is an M&M book which capture all adverse incidents, near misses and deaths which is discussed within M&M meetings where the middle tier is encouraged to present cases for discussion. There is also a review of themes undertaken on a yearly basis.

FY1/CT/ST: RDITs believe that they would be supported by the department if they were involved in an adverse incident and would discuss with their supervisor. They are aware of M&M meetings however noted the general environment at these meetings as tense.

Nurse/AHP: The team reported that the department try to foster multi-disciplinary learning after a significant event which is shared with all staff. The nursing team do not routinely attend M&M meetings.

2.21 Other

Overall Satisfaction Scores: n/a.

SAS Doctor/Specialty Doctor/Clinical Development Fellow Session

Induction: Doctors noted no specific induction or handbook available to them however they are given the opportunity to shadow shifts and clinics. They believe the induction for FY1s is excellent.

Teaching: Doctors stated that RDITs inform the nursing team and on call when they have a formal teaching session to attend and handover bleeps. They noted contributing to informal departmental teaching. They also prepare for the CME and surgical radiology meetings which take place monthly. Dates and information are distributed in advance and RDITs are encouraged to present at journal clubs.

Supervision: Doctors reported having a named supervisor and most confirmed having opportunities for personal development however there were some concerns raised regarding lack of engagement to develop personal interests. Those who are formally recognised trainers felt well supported to undertake the role. They are aware of who is providing clinical supervision during the day and out of hours.

Adequate Experience (assessment): Doctors confirmed providing workplace-based assessments for RDITs.

Feedback: Doctors commented that they are provided with opportunities to feedback to senior colleagues however depending on who the senior is they may not feel comfortable in doing so.

Workload: Doctors stated that the rota has been reviewed several times, and they do not believe it provides a good work life balance. CDFs, specialty doctors and CT/ST contribute to the same level of the on call rota (middle tier). CDF/CT/ST attend elective theatre lists on either consultant or specialty doctor lists at least one full day per week and specialty doctors provide independent clinics and operative activity scheduled on the rota which RDITs are welcome to attend. CT/ST/CDFs also contribute to managing the surgical hot clinic/ambulatory care. Concerns were noted regarding the late release of the elective rota which is released on a Friday for the coming week which makes

planning very difficult. They believe that the needs of the CT/ST are put above permanent members and do not consider allocations to be fair. They commented that the positive aspects of the rota are that personal interests are considered along with annual leave and study leave.

Culture and Undermining: Doctors reported variable levels of support which are dependent on who the on call consultant is. They reported on having been subject to and of witnessing behaviours of bullying and undermining which have been escalated however no change has been noticed. They noted that M&M meeting are particularly difficult for interactions between people. They noted work undertaken on Civility Saves Lives and Active Bystander and of the adoption of the TBQR pilot however have again noted no improvements. A specialty doctor has taken responsibility for co-ordinating M&M and TBQR however this is in the early stages and training for most is yet to be undertaken. Significant concerns remain regarding the culture within the department which was referred to as toxic.

Support: Doctors reported that consultants provide support to the on call consultant and will step in to help to allow a break if workload is heavy.

Patient Safety: Doctors believe in general the department is safe. They raised concerns regarding being on call for 24 hours and attending theatre the next day which they consider to be unsafe for the person and patient.

Adverse Incidents and Duty of Candour: Not asked due to time constraints.

3. Summary

Is a revisit required?	**Yes**	**No**	

The panel commended the engagement of the medical education team in facilitating and supporting the in-person visit and noted the considerable efforts and improvements being made to provide a safe training environment. The panel acknowledge the attendance of NHS Borders Board Chair. Serious concerns remain regarding patient safety, the learning environment and culture. Allegations of bullying and undermining were discussed with the Medical Director, Associate Medical Director and

Director of Medical Education immediately after the visit. The panel also noted positive comments relating to hospital induction, departmental teaching, educational supervision, adequate experience, handover, raising concerns and adoption of the TBQR process. Areas for improvements were noted as rota, boarders, departmental induction and regional teaching. 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:

- Patient Safety
    - Concerns raised regarding cover arrangements for Urology to ensure appropriate cover is in place with clear responsibilities for the care of these patients.
    - Concerns raised regarding 7-day consultant on-call.
- Learning Environment and Culture
    - Concerns remain regarding team culture, inter-professional relationships and the psychological safety of members of staff. An allegation of bullying/undermining behaviours and misogynistic comments were raised and discussed with the Medical Director, Director of Medical Education and Assistant Medical Director directly after the visit.

Positive aspects of the visit:

- Excellent engagement from the Medical Education team and site management team in supporting the visit.
- Recognition of efforts, engagement and improvements made to date.
- Resident doctors in training (RDITs) described robust hospital induction.
- FY1s reported attending the majority of their regional teaching sessions and of being able to attend monthly departmental teaching.
- All RDITs confirmed having designated educational supervisors who they meet regularly. They are always aware of who is providing clinical supervision during the day and out of hours. FY1s reported good opportunities to attend clinics and theatre sessions. STs highlighted allocation to elective cases as a particular strength with cases carefully thought-out.
- All RDITs described being able to meet all competencies with well supported workplace-based assessments.
- RDITs noted good opportunities to be involved with quality improvement projects.

- FY1s described receiving regular useful informal on the job feedback which is of benefit to their learning.
- RDITs noted attending regular meetings with the Medical Education Team and Clinical Director where concerns regarding training and education can be raised.
- FY1s reported structured and safe handover as taking place with opportunities for discussion and learning.
- FY1s reported feeling comfortable in raising concerns regarding patient safety with senior colleagues who they find approachable.
- Ongoing adoption of the TBQR process.

Less positive aspects of the visit:

- Concerns were raised regarding the on call rota and weekly allocation of duties. The on-call rota is only released a month at a time and the weekly plan on a Friday for the forthcoming week. This is considered to be due to brinksmanship of those working on the middle grade rota. Examples were provided of last-minute swaps/changes which are variably communicated to the rota co-ordinator.
- It remains unclear who is responsible for patients boarded into Surgery in particular T&O. These patients are managed by parent teams and FY1s should undertake day to day management of these patients however Medicine and Gynaecology undertake most tasks with no interaction with FY1s. These patients are not included in handover.
- No formal departmental induction for the second cohort of CTs. No induction handbook for CT/ST which would be of particular use if coming from a different health board.
- ST reported attending less than half of the regional teaching sessions due to on-call commitment. The CT has only been able to attend sessions after the event from home due to rostering pressures and inadequate Wi-Fi connectivity on site.
- Poor Wi-Fi is having a negative impact on education with RDITs having to undertake research or access teaching and portfolios from home.
- CT/ST reported limited formal feedback on day-to-day work unless sought out directly.

4. Requirements from previous visit June 2025

Progress against previous requirements recorded as ‘addressed’, ‘significant’, ‘some progress’, ‘little or no progress’.

Ref	Issue	Resident doctor cohort in scope	Progress
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.	FY1	Some progress
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.	All	Little progress
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.	FY1	Some progress
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.	All	Some progress
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	All	Some progress

	protecting time for attendance.		
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.	FY1	Some progress
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.	CT/ST	Some progress
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.	All	Some progress
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. (CLOSED 23rd April 2026)	FY1	Closed

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
2.15	Poor Wi-Fi is having a negative impact on education with RDITs having to undertake research or access teaching and portfolios from home.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1 – 6.8	Carry forward from previous visit report requirements		
6.10	Barriers preventing trainees attending their dedicated teaching days must be addressed.	February 2027	CT/ST
6.11	Trainers within the department must provide more regular formal ‘on the job’ feedback, particularly in regard to resident doctor decision making and care planning.	February 2027	CT/ST