

Scotland Deanery
Quality Management Visit Report

Date of visit	23 rd June 2026	Level(s)	Foundation, Core, Specialty
Type of visit	Triggered	Hospital	Forth Valley Royal Hospital
Specialty(s)	Trauma & Orthopaedic Surgery	Board	NHS Forth Valley

Visit Panel	
Dr Alastair Campbell	Visit Chair – Deputy Lead Dean/Director
Dr Cieran McKiernan	Associate Postgraduate Dean (Quality)
Dr Karen Rose	Foundation Programme Director
Mr Eddie Kelly	Lay Representative
Miss Fiona Paterson	Quality Improvement Manager
In Attendance	
Miss Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine, Surgery, Occupational Medicine & AICEM
Lead Dean/Director	Dr Greg Jones
Deputy Lead Dean/Director	Mr 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	✓
Resident Doctors in attendance	FY ✓ Core ✓ ST ✓

Feedback session: Managers in attendance	Chief Executive	0	DME	✓	ADME	✓	Medical Director	✓	Other	✓
Report approved by Lead Visitor / Lead Dean		09/07/2026								

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 site delivered a presentation outlining areas of good practice, areas for improvement, and ongoing quality improvement work. Further detail is provided in the report below.

2.1 Induction (R1.13):

Trainers: Feedback from previous FY doctors prompted a review of their induction. This is now led by a new consultant and provides a more detailed, multi-disciplinary and holistic approach. To help improve induction for FY2 doctors, there are plans to include sessions from specialties that are covered out of hours (OOH) such as maxillofacial and plastic surgery. Core and ST induction combines both formal and informal elements. A specialty doctor delivers induction as part of their job plan.

FY: Induction mainly focused on general surgery with limited T&O-specific content. A previous FY1 provided a booklet covering day-to-day working in the department which was said to be useful.

Core & ST1-8: Department induction was registrar led, there was no induction provided from urology or other surgical specialties, despite these being areas covered out of hours for Core/ST1-2. A quality improvement project was completed to develop an induction booklet in the form of a pocket guide.

Hospital Induction

All RDiT: All received induction, some ST3-8 RDiTs reported delays to log in details and security access.

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

Trainers: Trainers told us they have revised the Monday morning X-ray session and made it mandatory for all RDiTs to attend, this session is also built into consultant job plans.

The department run several half-day sessions throughout the year which include RDiT-led presentations, where they share both their best and most challenging cases. As part of a separate session consultants will present their most complicated cases for learning also. RDiTs can also attend journal club and audit meetings.

FY, Core, CDF & ST1-2: RDiTs reported no formal departmental trauma and orthopaedics teaching programme in place. Some junior registrars and a small number of consultants provide useful ad hoc teaching. While RDiTs are generally able to attend mandatory teaching and have the option to attend clinics and theatres, this is often restricted by low staffing levels. We were told a small number of informal sessions took place at the start of the year, but these were mainly aimed at medical students and FY.

ST3-8: Similar to their colleagues the ST3-8 RDiTs reported learning opportunities were mainly ad hoc, occurring during trauma meetings and on-call shifts rather than through a formal teaching programme. We were told a consultant had recently introduced weekly teaching sessions however, attendance had been low, which led to sessions being rescheduled to 20:00 (out with working hours).

2.3 Study Leave (R3.12) Not asked, no concerns raised in PVQ

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

Trainers: For specialty training (ST) doctors in the region, the Training Programme Director works with the Specialty Training Committee to allocate consultant trainers, based on specialty interests,

level of competence, and any additional support needs. Foundation & Core doctors are allocated both an Educational Supervisor and a Clinical Supervisor for each placement.

All RDiTs: RDiTs 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.

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: RDiTs have easy access to informal peer and senior advice within clinical areas. A departmental coffee room is available and is regularly used by consultants, providing RDiTs with easy access to senior advice and support when required.

FY: FY's reported that the recent introduction of a dedicated mid-grade ward support role for the afternoon (12–5pm), had been beneficial in managing workload. However, they noted that this role is frequently redeployed to theatre during periods of staffing pressure, resulting in ward cover being provided primarily by FY1 doctors. Positive feedback was received regarding the support provided by the orthogeriatric team. Some FY doctors highlighted concerns about accessing timely support for medically unwell patients commenting that there can be a tendency to seek advice directly from the medical registrar rather than through the local supervisory arrangements.

Core & ST1-2: RDiTs are aware of clinical supervision arrangements within the T&O department; however, out-of-hours cover for other specialties can leave them feeling outside their level of experience.

ST3-8: Consultants were consistently available during the day and OOH. RDiTs reported no difficulties in contacting them, with support provided by other consultants when needed.

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

Trainers: Trainers shared the challenges of providing access to elective exposure. FY rotas include defined clinic allocations for elective clinics, trauma work and theatre sessions. Core and ST

exposure is weighted towards trauma rather than elective work. Although low theatre numbers are a recognised ARCP issue nationally, in this region RDITs report good operative exposure.

FY: The Surgical Assessment Unit provides good opportunities for assessment sign-off; however, opportunities outside of this area were said to be limited. They felt much of their time when working on the ward was taken up with tasks they perceived as non-educational.

Core & ST1-2: RDITs reported no barriers to achieving their workplace-based assessments. Clinical development fellows noted they have less opportunities to attend theatre than their training programme colleagues.

ST3-8: Overall, RDITs reported good exposure to trauma work, with reliable access to theatre (around 2.5 sessions per week). Access to elective clinics is limited, with many not scheduled to attend. Some access during their SPA time, however this is often not feasible due to rota pressures. There noted some gaps in achieving specific competencies but recognised this was a national issue.

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

Trainers: Not asked due to time constraints

RDITs: Reported within 2.6

2.8 Adequate Experience (multi-professional learning) (R1.17) Not asked, no concerns raised in PVQ

2.9 Adequate Experience (quality improvement) (R1.22) Not asked, no concerns raised in PVQ

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

Trainers: Feedback to RDITs is delivered through 1 to 1 clinical supervision and structured processes. Day-to-day feedback is provided via one-to-one teaching in theatre, consultant review of referrals at the trauma meeting, and case discussions within clinics. Formal feedback is provided through multi-consultant reports (MCR), with trainers meeting on a six-weekly basis to compile.

FY, Core & ST1-2: FY's reported variable feedback provided by their senior colleagues. Core & ST1-2 doctors reported patients are reviewed at the Trauma meeting and feedback provided on management plans. They can discuss cases with supportive senior registrars and if confident, they manage cases independently; if not, seniors step in and give feedback.

ST3-8 RDiT: Not asked due to time constraints, no concerns raised in PVQ.

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

Trainers: Intercollegiate Surgical Curriculum Programme (ISCP) is used to gather formal feedback from RDiTs. Feedback from GMC and STS surveys is also reviewed and reflected on. This has led to changes including adapting the FY induction, introducing an orthogeriatric team, and improving escalation policies.

FY: An example of providing informal feedback that improved support for discharge letters was provided. They were unaware of any formal mechanisms.

Core & ST1-8. RDiTs stated there are informal opportunities to raise issues, supported by a flattened hierarchy and approachable consultants. Some noted that consultants are open to discussing their experience, including how the site compares to others. Formal routes to provide feedback, included surveys such as the GMC and Scottish Training Survey, or through their CS, ES, or TPD.

2.12 Culture & undermining (R3.3)

Trainers: To help RDiTs feel valued and included, the department organise social events such as Summer and Christmas gatherings which help build relationships in a non-clinical setting. Trainers noted that large meetings can feel intimidating. However, they felt RDiTs are gaining confidence in speaking up, supported by others doing the same within a no-tier hierarchy.

All RDiTs: All reported that the team are friendly and supportive. However, junior doctors can feel pressured when clinical workload is high and rota cover is tight. An incident was reported by a

previous cohort concerning perceived demeaning behaviour by a senior charge nurse; however, it was subsequently confirmed that this has been resolved.

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

Trainers: Not asked due to time constraints

All RDiT: Occasional rota gaps were reported. Cross-cover arrangements are in place with the surgical wards for juniors, although the level of support available depends on clinical workload within those teams. The senior rota is down 1 registrar.

2.14 Handover (R1.14)

Trainers: Handover is supported through an electronic system and a rota design that includes overlapping shifts to facilitate safe transfer of patient care and clinical review.

FY: They attend morning ward-to-ward handover with the night team. Within the ward, a further handover takes place between the medical team and the nurse in charge.

Core & ST1-8: RDITs reported that the number of handovers throughout the day can be excessive and disrupts continuity of patient care. Despite this, they described the handover process as well supported, with appropriate opportunities to seek advice and discuss clinical issues.

2.15 Educational Resources (R1.19) Not asked, no concerns raised in PVQ

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) Covered in 2.18

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) Not asked, no concerns raised in PVQ

2.18 Raising concerns (R1.1, 2.7)

Trainers: RDiTs are encouraged to raise patient safety concerns from induction onwards and are made aware of the available escalation routes. There are measures to support RDiT wellbeing and safety, including access to on-site accommodation while on call and security escorts when required. Clinical and non-clinical managers were described as approachable and responsive and spend time with RDiTs providing another route to raise concerns.

FY: FYs would raise patient safety concerns via the charge nurse or ANP in the first instance.

Core & ST1-8: Concerns would be raised via standard channels and addressed appropriately.

2.19 Patient safety (R1.2)

Trainers: Not asked due to time constraints

FY, Core & ST1-2: They had no concerns regarding the quality or safety of care within orthopaedics, they again highlighted the challenges of accessing appropriate medical support. Core & ST1-2 noted concerns regarding end-of-life care on the wards describing delays in decisions to withdraw active treatment in some cases. They suggested that consideration of DNACPR status and clarifying ceilings of care at the point of admission would be helpful.

ST3-8: RDiTs reported no concerns regarding patient safety within the department.

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

Trainers: Not asked due to time constraints

All RDiT: They had not experienced an adverse incident but reported confidence that they would receive appropriate support through a supportive line manager and wider team.

2.21 Other: Specialty doctors in training and their trainers highlighted reduced exposure to elective work, with service pressures limiting training opportunities in this area.

3. Summary

The panel found no immediate concerns regarding patient safety, RDIT safety, supervision, culture, or workplace behaviour. RDITs consistently described supportive trainers, good surgical training opportunities and clear escalation pathways. However, concerns were identified around the consistency of induction, limited or variable formal teaching provision, difficulties accessing some training opportunities due to service pressures and challenges obtaining workplace-based assessments in some areas. Core Surgical doctors reported a less positive experience than specialty doctors, frequently describing service demands taking priority over education, reduced access to clinics and theatre, and feeling undervalued as doctors in training. Workforce pressures and the management of medically complex patients on orthopaedic wards were recurring themes.

Is a revisit required?	Yes	No	Dependent on outcome of action plan review
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Positive aspects of the visit:

- No immediate patient safety concerns relating to orthopaedic surgical care and no concerns about resident doctor in training (RDIT) safety at any site
- Approachable and supportive group of trainers across all sites. Strong enthusiasm to innovate and improve training in trauma and orthopaedics, supported by proactive and dynamic non-clinical management teams
- Positive workplace culture with a strong focus on training and education. No concerns around workplace behaviour were heard on any of the sites.
- The surgical experience for T&O RDITs at all sites was very positive in particular in terms of unscheduled operating
- Formal supervision is working well on all sites.
- There was evidence of ongoing work to improve induction, supported by management teams.
- Clear escalation pathways and processes are in place across all sites, supported by technology
- Feedback provided to T&O RDITs is valuable and well received

- No significant rota gaps were described on any sites. Work is ongoing across all sites to increase workforce numbers and support access to training for those in training programmes (e.g. ANPs, CDFs).

Less positive aspects of the visit:

- Ongoing work to improve departmental induction, with further development required. Challenges include ensuring consistency across the training year and that the induction process meets the needs of, and prepares, RDITs for work within the unit
- Local formal teaching is challenging across all sites. It needs to better meet the needs of RDITs and be more accessible, with support from senior consultant colleagues, while recognising ongoing workforce pressures.
- While the T&O RDITs reported a positive surgical experience, core surgical RDITs had a less positive experience which should be reviewed.
- FY doctors told us that achieving WPBAs was more challenging than in other areas.
- Workforce pressures are affecting all doctors and medical complexities of patients on inpatient wards poses challenges to services. There are perceived patient safety concerns in relation to management of medical problems on orthopaedic wards

4. Areas of Good Practice

Site	Item
Forth Valley	The Monday morning X-ray meeting has been redesigned and made mandatory, with attendance embedded within consultant job plans.

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.

Forth Valley	Item	Action
5.1	Some ST RDiTs reported delays obtaining logins and security access.	The department should review processes for IT and access permissions to ensure RDiTs can fully undertake clinical and educational activities from the start of placement.
5.2	FY's stated their induction mainly focused on General Surgery with limited T&O information.	Review the FY induction programme to ensure it includes an appropriate level of T&O input.
5.3	Although escalation plans are in place some junior RDiTs stated they felt unsupported when dealing with medically unwell patients on the ward.	Review ward support arrangements for junior RDiTs to ensure timely access to senior clinical advice when managing medically unwell patients
5.4	RDiTs stated the volume of handovers can feel excessive.	Review handover arrangements

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	An induction or induction manual/guide must be provided to RDiTs who cover multiple specialties overnight.		FY, Core & ST1-2
6.2	There must be a protected formal teaching programme for doctors in training		All