

Scotland Deanery
Quality Management Visit Report

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

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	Professor Adam Hill
Deputy Lead Dean/Director	Dr Alastair Campbell
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 ✓ 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: The department had received good feedback regarding induction. It is well structured across 2 days with practical arrangements such as IT access etc organised. As DGRI is a remote site, accommodation is provided. Departmental induction is less formal due to the size of hospital. RDITs are not scheduled to be on call when starting to ensure full attendance, with permanent staff covering this period instead. It is consultant led with input from peers detailing roles and responsibilities. Feedback is sought and changes made as required.

All RDIT: For FYs induction was delivered as part of a general surgical programme with limited trauma & orthopaedics included. ST3-8 RDITs reported a good induction which prepared them well for their role in the department.

Hospital Induction

All RDIT: All RDITs received hospital induction.

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

Trainers: Thursday mornings are used for local teaching, set within a departmental meeting focused on clinical case discussion. Staff and specialty doctors provide cover to support attendance.

Attendance can vary and be low at times. Consultants discuss a mix of cases including straightforward and more challenging examples. They also share cases where wider consultant input would be helpful which supports discussion and shared learning across the team.

FY: FY's reported limited formal teaching estimating around five minutes of teaching per week. One trainer was noted to be passionate about teaching and provides ad hoc sessions. They can attend mandatory FY teaching with no barriers.

ST3-8: There is weekly teaching every Thursday which is accessible if not scheduled on call or night shift. The teaching was noted to be relevant and of a good standard.

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 doctors are allocated both an Educational Supervisor and a Clinical Supervisor for each placement.

All RDIT: 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: There is clear guidance in place, with an on-call registrar as the first point of contact, followed by consultant support where needed, providing 24-hour cover. There is no strict hierarchy

and staff are encouraged to seek help from whoever is available. Referrals may come directly from nursing staff and are accepted without issue

FY: They are aware of escalation processes, but report limited practical support as the registrar is often on call and unavailable, leaving them to relay messages via the scrub nurse. While registrars are generally helpful with Trauma and Orthopaedic queries, they are perceived as less supportive with medical issues. There is a well-regarded orthogeriatric team, aligned to Care of the Elderly, who provide input; however, this support is not formally coordinated through T&O. Some reported they felt they had worked above their level of competence due to non-resident registrar availability.

ST3-8: There were no reported issues accessing supervision in either theatre or clinic. Consultants were described as approachable.

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

Trainers: The department has no junior tier of T&O RDITs (ST1/2), which limits capacity and places pressure on available elective clinic delivery. Wider hospital pressures have reduced available space, with services displaced and elective activity affected by cancellations.

Despite this, the department focuses on maintaining training quality. A multi-consultant rota is in place, though this can lead to lack of continuity for RDITs. There is also a second consultant-led trauma operating list each morning which provides structured teaching and close supervision.

FY: FY's reported ongoing difficulty in completing workplace-based assessments (WPBA's) to evidence competencies. This group of FY doctors had achieved most of their Foundation curriculum competencies as this was the last block of the training year. Senior staff are usually only available during morning ward rounds and then spend the rest of the day in theatre, which limits opportunities for sign-off. This is described as a common issue across surgical specialties, with FY's trying to compensate by arranging supervised learning activities in other specialties.

ST3-8 The absence of ST1/2 level RDITs in T&O within the department was reported to have impacts on workload distribution and support. The rota design does not align with allocated clinical supervisors, which can make continuity of supervision and training more challenging. Opportunities to

gain trauma experience, often requires RDITs to swap shifts. Consultants are generally supportive; however, RDITs felt that access to operative opportunities could be influenced by the extent to which individual consultants were familiar with their capabilities. In addition, some consultants need to be followed up to complete WPBAs.

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: Most feedback is provided in real time. Where concerns arise regarding a RDIT, efforts are made to discuss these promptly and determine whether they relate to an isolated incident or a recurring pattern of behaviour. Where a pattern is identified, this is documented to provide support to the RDIT. A weekly Thursday morning meeting also provides a structured opportunity for case discussion and feedback.

All RDIT: No response within meeting.

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

Trainers: Trainers can request formal feedback from RDITs through the Intercollegiate Surgical Curriculum Programme (ISCP) process. There is no established mechanism for formal feedback outside this structure. Most feedback is gathered through informal discussions.

All RDiT: Were unaware of any formal opportunities to provide feedback. However, the FY's noted that senior staff in General Surgery carry out regular check-ins.

2.12 Culture & undermining (R3.3)

Trainers: Trainers told us the culture within the department is positive and they have zero tolerance to bullying and undermining. Due to the size of the department and location of the hospital there are less formally organised social events due to RDITs wishing to return home at the end of their shift.

All RDiT: They described the department as a supportive environment within a small hospital setting, with approachable staff and clear escalation pathways to senior teams. Although FY's reported direct contact with consultants was limited at times, they were reported to be responsive and supportive when approached.

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

Trainers: Not asked due to time constraints

All RDiT: There were no obvious rota gaps identified, although annual leave and sickness absence can impact rota coverage.

2.14 Handover (R1.14)

Trainers: Registrar OOH shifts overlap allowing time for patient reviews, handover, and clinical support. The department also uses an electronic trauma management system to support the recording and communication of patient information.

All RDiT: A single FY1 covers all trauma admissions overnight and is required to hand over to two separate teams in the morning, which can make the handover process slightly challenging.

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: Trainers highlighted that patient safety is embedded within the department's culture, with DATIX used as the formal mechanism for reporting concerns. Measures are in place to manage challenging situations, including access to security support and where necessary police attendance on site. The clinical environment was described as open and well designed, with individual rooms featuring glass panels to enhance visibility and safety.

All RDiT: RDiTs reported no issues in raising concerns. They described a positive safety culture within the multidisciplinary team.

2.19 Patient safety (R1.2)

Trainers: Not asked due to time constraints

All RDiT: They reported confidence in the quality and safety of care particularly within elderly care services, which were described very positively. Consultants were said to be approachable and responsive to concerns.

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. 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
- Approachable and supportive group of trainers. 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, 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 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. It needs to better meet the needs of RDITs and be more accessible, with support from senior consultant colleagues, while recognising ongoing workforce pressures.
- FY doctors told us that achieving WPBAs was more challenging than in other areas.

4. 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
4.1	Some RDITs reported delays obtaining WPBA sign-off.	The department should review arrangements for completion of workplace-based assessments to ensure timely sign off.
4.2	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. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
5.1	Departmental induction to T&O must be provided which ensures RDiTs are aware of all of their roles and responsibilities and feel able to provide safe patient care.		FY
5.2	A regular programme of formal T&O teaching should be introduced appropriate to the curriculum requirements for FY RDiTs		FY
5.3	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		FY
5.4	A formal mechanism for all RDiTs to be able to feedback to the department must be established.		All