

Scotland Deanery
Quality Management Visit Report

Date of visit	23 rd June 2026	Level(s)	Foundation, Core, Specialty
Type of visit	Triggered	Hospital	University Hospital Crosshouse
Specialty(s)	Trauma & Orthopaedic Surgery	Board	NHS Ayrshire & Arran

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 Presentations: 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: Following feedback, the induction process has been refreshed to give resident doctors in training (RDiTs) a broader and more practical introduction to the department. It includes a structured tour, ID and IT setup and clear expectations of what is required of RDITs working in T&O. For FY doctors it provides an introduction to orthopaedics focusing on key areas such as wound management, suturing and approaching patients from a ward-based perspective. Teaching sessions cover frailty, geriatric assessment and developing treatment plans. Clinical activity for consultants involved in delivering induction is cancelled to allow them to attend.

Training opportunities are expected to include a 4–6 month taster in out-of-hours and acute presentations, alongside exposure to Hospital at Night (HAN) work. The current rota model varies across two sites, with one not having an acute orthopaedic take. There are plans to move to a single receiving night shift from August. This should help ensure RDiTs gain consistent experience with two FY2s on shift at the same time for peer support and sense-checking. Middle-grade doctors are not part of the on-call team, the current setup is seen as working reasonably well and there is concern that changes could impact the positive feedback currently received.

All RDiT: RDITs told us that they received a good induction at the site. Those that were able to attend on the day were protected from clinical work which was appreciated. Those joining out of step received a comprehensive 1 to 1 induction which was consultant delivered. ST3-8 RDITs noted that they cover multiple sites for clinics and these were not included.

Hospital Induction

All RDITs: All RDITs received hospital induction however some ST3-8 doctors reported a delay to log in and security access.

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

Trainers: Trainers reported there is a variety of informal, on the job and formal teaching within the department. The junior cohort can access weekly lunchtime teaching, which is planned around rota patterns to maximise attendance with advanced nurse practitioners (ANP) providing ward cover. Regional teaching is protected with clear arrangements in place to support attendance. Twice-daily trauma meetings while primarily operational, are also used to support learning through discussion of clinical decision-making and key learning points. Additional opportunities include journal club sessions and teaching dinners.

FY: They can access weekly FY1 teaching and junior departmental sessions.

Core & ST1-2: There is consultant oversight of junior teaching sessions, although they are not consultant-led. RDITs prepare and deliver topics to their peers. Attendance can be limited due to clinical commitments.

ST3-8: RDITs reported that they were not aware of any regular weekly teaching sessions. However, they described informal teaching as being of good quality and stated that they had not experienced any difficulties being released to attend regional teaching.

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.

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 are supported through consistent access to senior advice and clear escalation pathways. There is always a registrar on site who can be contacted readily for day-to-day support. While OOH cover has previously been identified as a challenge, this has been addressed through the introduction of a clinical escalation policy and a 2nd on call consultant. This provides a structured route for seeking additional support, particularly in situations where orthopaedic consultants may not be best placed to advise on medical issues, with RDITs directed to escalate to medical team when appropriate.

All RDITs: Most RDITs reported accessible and approachable supervision. Registrars attend overnight if called, and they are accessible when needed. On call registrars ensure that they make contact at the start of the shift and encourage staff to contact them and escalate any concerns. Some junior RDITs said it can be difficult to access support in a timely manner if their supervisor is based at another site.

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

Trainers: Trainers advised that the rolling rota is fair and balanced, but it relies on RDITs swapping on-call shifts to access their clinical supervisor's operating list and gain the best experience. Trainers noted that attendance at elective clinics needs to improve, as it depends on RDITs taking the initiative. ST1–2 RDITs are prioritised for trauma theatre and fracture clinics, while FY2 and CDF

doctors receive appropriate development time and are encouraged to attend both clinics and theatre to support their learning.

FY, Core & ST1-2: FY doctors had no concerns relating to adequate experience in the role. Some RDITs reported difficulty accessing operating lists appropriate for their level of experience. Cases are often prioritised for T&O specialty RDITs, limiting opportunities for others. This can leave RDITs feeling undervalued. While many have assisted in procedures, this has not translated into opportunities for independent operating.

ST3-8: The training experience was described as generally positive, with good exposure to fracture and elective clinics supporting core learning. Two daily trauma lists provide regular operative opportunities, though access can be variable. Clinic experience, particularly fracture, supports decision-making, but service pressures can limit hands-on teaching. A recognised gap in paediatric trauma remains; however, the regional model of six months in a children's hospital is seen as a practical way to address this.

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 is given regularly throughout the day, both informally during ad hoc discussions and in theatre, where cases are reviewed and reflected on. OOH feedback is provided at trauma meetings, where cases are discussed, highlighting what went well and areas for improvement.

For more serious concerns, feedback is delivered through a planned, face-to-face discussion to ensure it is handled appropriately and constructively.

FY: Opportunities for feedback were limited with FY's estimating they received feedback less frequently than weekly.

Core & ST 1-8: Informal feedback is provided daily at the trauma meeting and clinics. WPBA's and training surveys also provide opportunities.

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

Trainers: Formal supervision provides a structured opportunity for one-to-one discussion. Feedback is also collected through MS Forms surveys. Informal feedback is gathered through day-to-day conversations, often in shared spaces such as the coffee room where RDiTs and senior staff interact. In addition, there is a quality management meeting that the Clinical Director and DME attend to review feedback, share outcomes, and monitor improvements.

FY: They reported they can provide feedback after teaching sessions.

Core ST1-8: There are regular opportunities to share views through the GMC, Intercollegiate Surgical Curriculum Programme (ISCP) and NHS Scotland surveys, as well as during placement discussions and appraisal meetings. Informally they can discuss with consultants at any time.

2.12 Culture & undermining (R3.3)

Trainers: The trainers again highlighted the coffee house as a key area supporting team culture, describing it as the social heart of the department where informal conversations, peer support and discussion of sub-specialty referrals can take place. There were regular social events, including a well-supported annual Christmas night out funded by consultants, which current and past RDiTs attend. All staff have also completed active bystander training, reinforcing a shared responsibility to challenge and prevent undermining and bullying behaviours.

All RDiT: Overall, RDiTs stated they work within a friendly, supportive team.

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

Trainers: Not asked due to time constraints

All RDiT: No gaps were reported by FY or Core RDiTs. However, Specialty RDiTs highlighted that known gaps arising from less than full-time (LTFT) working arrangements are often not backfilled.

2.14 Handover (R1.14)

Trainers: Trainers described trauma meetings as the primary mechanism for clinical handover. Day-to-evening handover is facilitated by the backshift doctor taking responsibility for the pager. The department utilises an MS Teams-based handover system, although its effectiveness is dependent on staff keeping information accurate and up to date.

All RDiT: Handover at the trauma meeting was reported to be effective, safe and efficient.

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 reported that RDiTs are encouraged to raise patient safety concerns through formal reporting mechanisms, including DATIX, and via an online feedback form within the Teams channel, which can be submitted anonymously. Accommodation is available at both sites for those working night shifts. They acknowledged that night working remains the most challenging aspect of the rota and can at times feel difficult to sustain due to service pressures. Staffing arrangements have been reviewed and additional cover introduced where possible, although trainers noted that improvements remain constrained by available resources.

All RDiTs: They described longstanding challenges in the relationship between the Emergency Department and Trauma & Orthopaedics and felt that concerns raised about these issues are not consistently addressed.

2.19 Patient safety (R1.2)

Trainers: Not asked due to time constraints

FY: No concerns were raised.

Core & ST1-3: RDiTs described differing models of senior oversight across sites. In Ayr, ward-based care was reported to rely largely on an ANP and ward doctor, with consultant input available when requested. In Crosshouse, the attending consultant model was viewed positively in principle; however, RDiTs noted that patients may not always receive regular review by the same clinician. Peri-operative medicine input was considered beneficial, although it was reported that reviews were often undertaken by more junior members of the team.

ST3-8: RDiTs recognised the high demand and pressures within the unit. However, they reported that a lack of available clinical space can create challenges in assessing patients in a timely manner.

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

Trainers: Not asked due to time constraints

All RDiTs: 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
AA	Consultants have clinical activity cancelled to allow full participation in induction.

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	ST3-8 RDiTs noted that T&O induction did not fully cover all sites they attended for clinic activity.	The department should review induction arrangements for RDiTs working across multiple sites to ensure all relevant locations, processes and expectations are covered.
5.2	RDiTs described ongoing tension between the department and the Emergency Department. They felt raised concerns were not addressed	The department should review the interface between departments and demonstrate concerns are being addressed.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	A regular programme of formal T&O teaching should be introduced appropriate to the curriculum requirements for ST RDiTs		ST3-8