Public Services Delivery
Scotland

NHS SCOTLAND

SCOTLAND DEANERY QUALITY MANAGEMENT: VISIT REPORT

Date of visit	29th September 2026	**Level(s)**	FY, CT & ST
Type of visit	Triggered	**Hospital**	Dumfries and Galloway Royal Infirmary
Specialty(s)	General Surgery	**Board**	NHS Dumfries and Galloway

Visit panel	
Dr Kerry Haddow	Lead Visitor
Ms Clare Carden	Training Programme Director representative
Dr Alexandra Rice	Foundation representative
Dr Jennifer Webber	Resident doctor in training representative
Mr David Soden	Lay representative
Mrs Natalie Bain	Quality Improvement Manager
In attendance	
Mrs Gayle Hunter	Quality Improvement Administrator

Specialty group information	
Specialty group	Medicine, Surgery, Anaesthetics, ICM & Emergency Medicine
Lead Dean/Director	Dr Greg Jones
Quality Lead(s)	Dr Reem Al Soufi Dr Fiona Drimmie Dr Kerry Haddow Mr Simon Gibson
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Miss Vhari MacDonald
Unit/Site Information	
Trainers in attendance	4
Resident doctors in training in attendance	11 FYs, 1CT & 2ST3

Feedback session: Managers in attendance									
Chief Executive		DME		ADME	x	Medical Director	x	Other	

Date report approved by Lead Visitor	6th October 2026
Date report approved by Lead Dean/Director	14th October 2026

SERIOUS CONCERNS	**Yes**	✓	**No**	
THEME	Patient Safety			
ANY IMMEDIATE ACTION REQUIRED	NHS Dumfries and Galloway are aware of the issues highlighted in reference to patient safety and have mitigations in place to try and address them.			

PATIENT SAFETY
• RDiTs highlighted several potential patient safety concerns associated with current service pressures. • Bed pressures within the Surgical Assessment Unit continue to result in patients being managed across multiple locations, which can impact continuity of care despite good support from A&E. • Ongoing concerns were raised regarding the management of medical boarders, with a need for a clear and consistent escalation process. • Greater clarity is required around consultant ownership and discharge responsibility, particularly for patients in the short-stay unit and those with complex medical or palliative care needs.

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data, including the PSD Scottish Trainee Survey, a Deanery visit is being arranged to General Surgery at Dumfries & Galloway General Infirmary. The following Specialty Quality Management Group(s) requested this visit: Medicine, Surgery, Occupational Medicine & AICEM around the following concerns:

All Trainee Data: 3 red flags (triple red clinical supervision), Educational Environment and Handover.

Pink flag for Equality & Inclusivity

Foundation: 3 red flags - Clinical Supervision, Educational Environment and Handover

The visit aims to further investigate issues highlighted and to advise on steps towards addressing and resolving them where required.

2. Department Presentation:

The panel would like to thank for Ms Alison Bradley for her very detailed presentation and the team for the work that went into it. The presentation provided an overview of the organisation and ethos of the department overall. The presentation detailed the areas of good practice, as well as the challenges faced by the department as highlighted by the survey results. It was also helpful to hear about the changes already implemented to try to address the concerns highlighted in the survey results.

2.1 Induction (R1.13):

Trainers: The trainers report that there has been positive feedback received regarding the induction programme. Significant improvements have been made over recent years, including the introduction of a hospital-wide induction session delivered on the morning of commencement for ST3+ Resident Doctors in Training (RDiT). All receive an induction handbook and a departmental tour. Particular attention is given to ensuring accommodation arrangements are in place, recognising the challenges associated with a remote and rural training location. Foundation Year 1 (FY1) are attending their Preparation for Practice; therefore, their induction takes place one week before starting in post. They are divided into three groups (Surgical, Acute and Medical) and are guided through the roles, responsibilities and ways of working within each area. The induction handbook clearly outlines expectations and is reviewed and updated annually by the outgoing cohort.

Foundation: The FYs reported receiving corporate induction but no site tour, which would have benefited those unfamiliar with the hospital. They were aware of a brief handbook from a previous rotation, but this was not issued at the August induction. A consultant-led session covered shift arrangements and ward processes; however, it was felt that a site tour would have strengthened the induction.

Core & ST: Both CT and STs reported that they received a comprehensive full-day induction covering both hospital-wide and departmental orientation. This included meetings with IT and accommodation services, as well as a tour of the department. While they were aware of the induction handbook, it had not been emailed to them. Overall, all reported feeling well prepared and equipped to begin in post.

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

Trainers: The trainers note that foundation teaching is protected, the Medical Education Department supports bleep-free teaching. RDiTs currently have one hour of protected bleep-free teaching each Tuesday, with additional protected teaching sessions available on some Wednesdays. The department is working towards making all local departmental teaching bleep-free; however, this has not yet been fully achieved. During protected teaching sessions, the Education Department manages incoming calls and escalates urgent issues where necessary. ST3s are released to attend regional teaching, which is typically held on Fridays when clinical commitments are generally lower. Regional teaching is delivered in collaboration with the West of Scotland training programme, and RDiTs are encouraged to submit study leave applications to facilitate attendance. RDiTs have requested access to virtual teaching via Microsoft Teams links; however, this has not yet been routinely implemented. The teaching programme is mapped to the curriculum to ensure RDiTs are exposed to the required topics and learning outcomes throughout their training. The Clinical Teaching Fellow (CTF) is also working closely with FYs to develop and deliver a structured teaching programme, which is scheduled to commence in October.

Foundation: The FYs reported that they are able to attend surgical teaching on Fridays. This is mainly organised by the CTF to which the CTF has delegated presenting topics to the FYs. The FYs also have the mandatory teaching sessions on Tuesdays. Attendance at Tuesday teaching was reported to be good, while access to Friday sessions was more variable due to service commitments. It was felt that additional registrar-led teaching would be a valuable enhancement. The department was described as welcoming and supportive to learning.

Core & ST: The RDiTs reported having opportunities to teach FY doctors and are actively involved in delivering educational sessions. There are monthly half-day CME sessions organised where the STs and CTs have the opportunities to present. Departmental teaching is largely informal; it is noted that there are no significant barriers to attending teaching or obtaining study leave. The RDiTs are aware that there are plans to establish a middle-grade teaching programme, although this is still being developed. A suggestion was made to incorporate a regular 15-minute teaching session into the weekly departmental meetings.

2.3 Study Leave (R3.12)

All: Not formally asked, as no concerns were highlighted in either the survey or the RDiTs pre-visit questionnaire (PVQ).

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

All: Not formally asked, as no concerns were highlighted in either the survey or the RDiTs pre-visit questionnaire (PVQ). It was noted from the presentation that all trainers have an allocated RDIT and there is time in their job plan for this role. No concerns were raised throughout the visit.

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: The trainers reported that RDiTs are aware of who to contact both during the day and out of hours (OOH). This information is provided at induction and is displayed on posters in each of the wards. The trainers highlighted in the presentation and during the session that they are aware of that FY doctors have expressed feeling less well supported when providing care for shared care patients, particularly medical boarders. These concerns were discussed with the clinical team and escalated to medical colleagues for consideration. Medical patients are frequently boarded onto the ward with an anticipated short length of stay; however, this is not always achieved. When patients remain on the ward for longer periods or experience clinical deterioration, FY doctors can feel challenged in managing their care, particularly when a significant proportion of the ward comprises medical boarders. Although clear escalation processes are in place and concerns are promptly raised with the medical team, FYs have reported that these situations can impact their perception of clinical supervision and support, especially during weekends and out-of-hours periods when responsibility for such patients is often greater.

Foundation: FYs reported being aware of who to contact for clinical supervision, with clear team arrangements and rota information available to support this. While access to supervision was generally good both in and out of hours, delays could occur when senior clinicians were busy. Some RDiTs described occasions where reduced senior presence resulted in them managing issues beyond their level of experience while awaiting support. Although most registrars were considered approachable and supportive, it was highlighted that there is some variability in

responsiveness and the FYs would value telephone advice when immediate attendance is not possible. Some concerns were also raised regarding timely engagement from surgical teams in the management of medical boarder patients with urgent clinical issues.

Core & ST: The RDiTs reported that they are clear about who to contact for clinical supervision and are satisfied with the current rota arrangements. The rota enables continuity of supervision, with RDiTs consistently attached to the same consultant, providing a clear and supportive structure. There were no concerns regarding OOH supervision. Consultants were described as approachable, readily contactable, and supportive, with all feeling comfortable seeking advice when required**.** The RDiTs have not had any instances of working beyond their competence or experience.

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

Trainers: The trainers highlight that FY RDiTs are able to access theatre opportunities through the rota design, with the introduction of the float shift that can allow an FY to utilise any available opportunity to attend theatre. It's noted that there are weekly planning meetings, held on Fridays with CT and STs, which are used to review upcoming clinical activity and allocate learning opportunities appropriately. Senior registrars are routinely consulted to ensure equitable access to operative and educational experiences across all training grades. ST3s are reported to receive sufficient exposure to achieve the competencies required for their stage of training. The department also recognises that CTs have varying career interests and aims to provide flexibility in clinical experiences to support individual learning needs and professional development. The trainers believe that the FYs should have adequate opportunities to achieve their curriculum requirements during the placement. They are encouraged to complete competencies throughout the rotation, although it was acknowledged that portfolio completion can become concentrated towards the end of the four-month placement. Foundation Year 2 (FY2s) have dedicated development days that allow them to explore areas of specific interest. The rota is described as compliant and designed to support attendance at educational opportunities. A full phlebotomy service is available, reducing the need for RDiTs to undertake routine blood-taking. However, the trainers acknowledge that the FYs would spending a considerable amount of time completing patient discharges. The department advised that the doctor-to-patient ratio is approximately 1:10, which compares favourably with the GMC reference ratio of 1:14, suggesting staffing levels are generally sufficient to support training and supervision while maintaining service delivery.

Foundation: The FYs reported that completion of SLEs can be challenging due to limited senior availability. Although consultants were described as approachable and willing to support assessments, arranging observations could be difficult, even at this early stage of the placement. Attendance at departmental teaching was reported to be limited due to service commitments. Development days for FY2s and float shifts provide some access to training opportunities, including theatre experience for those with a surgical interest. All FYs highlighted a significant administrative workload, including time spent reviewing blood results, completing documentation and preparing EDLs. The reliance on handwritten notes and ward round documentation was viewed as inefficient and could result in the doctors remaining beyond their scheduled hours to ensure accurate handover to the HAN team. Concerns were also raised regarding the clarity of post-operative handwritten documentation, particularly within General Surgery. It was stated that there is variable phlebotomy support and communication issues were reported to have an impact on workload, with FYs occasionally undertaking blood-taking duties across multiple wards. Some also highlighted uncertainty regarding SSU processes and escalation pathways despite the availability of a flowchart. The shared electronic handover list was considered accessible and effective, with supporting written notes available where required.

Core & ST: All RDITs reported confidence in achieving their intended learning outcomes and curriculum requirements. All described having good access to clinics, quality improvement projects, theatre lists and endoscopy sessions, with consultants actively supporting and encouraging engagement in training and development opportunities. Clinic exposure is provided through both consultant-led clinics and, where appropriate, independent clinics for ST3s in line with their stage of training. Weekly rota planning meetings enable them to contribute to scheduling decisions and optimise access to educational opportunities relevant to their curriculum needs. The RDITs were satisfied with the range of training opportunities available, including the flexibility to utilise administrative days for additional theatre or endoscopy experience. Both CT and STs reported that they did not feel they were routinely undertaking tasks of limited training benefit.

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

Trainers: The trainers highlight that they are available to sign off assessments for all grades of RDiTs and encourage them to complete competencies throughout the rotation. Although it was

acknowledged that portfolio completion can become concentrated towards the end of the four-month placement for the FYs.

Foundation: The FYs emphasise that there is limited time during the working day for assessments, therefore making SLE completion challenging. It is also noted that follow-up requests may be missed. It's expressed that completing assessments at the time would therefore be beneficial.

Core & ST: Both CT and ST reported no concerns regarding completion of workplace-based assessments (WPBAs). The paired consultant model was viewed positively, supporting timely completion of assessments, ongoing monitoring of progress, and guidance on suitable activities and evidence for curriculum requirements. Both CT and STs described receiving appropriate support to complete assessments and achieve their training objectives.

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

Trainers: The department actively promotes multidisciplinary and cross-disciplinary teaching. The education team takes a proactive approach, with surgical residents frequently working alongside other team members to deliver teaching sessions. Clinical Medical Education (CME) teaching sessions are multidisciplinary in nature, providing opportunities for RDITs to learn with and from other professional groups. Similarly, Grand Rounds are delivered within a multidisciplinary setting, encouraging broader clinical discussion and shared learning. The trainers reported that cross-specialty and multidisciplinary teaching is well supported and actively encouraged, contributing to a collaborative learning environment and exposure to a diverse range of perspectives and expertise.

Foundation: Not formally asked due to time constraints, but it is demonstrated throughout the visit that the team regularly work with the wider MDT often.

Core & ST: The RDITs reported that they regularly work closely with the wider MDT and they would feel they would be able to approach anyone to work alongside them. It was highlighted that the scope team are extremely approachable and happy to accommodate the RDITs.

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

Trainers: The trainers state that the department actively promotes engagement in quality improvement activity. A buddy system is in place, pairing FY and STs, who frequently work together on quality improvement projects and service development initiatives.
Regular quality improvement meetings are held, providing a structured forum for RDiTs and supervisors to discuss project progress, share learning, and identify opportunities for further improvement. Outcomes from quality improvement projects are disseminated through a quarterly RI newsletter and there is an annual symposium is held where people have the opportunity to present their projects. This includes a prize-giving element, recognising and rewarding excellence in quality improvement and innovation.

Foundation: Not formally asked due to time constraints, however it was acknowledged that there are opportunities provided to the RDITs for quality improvement.

Core & ST: RDITs reported having many opportunities to participate in quality improvement projects and audits. Some described being involved in multiple projects simultaneously, with some also taking on supervisory roles to support FYs undertaking quality improvement work.

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

Trainers: Feedback is routinely provided at the end of ward rounds, following input from the wider multidisciplinary team and other services. This allows RDiTs to discuss clinical decisions and ask questions. FYs are encouraged to present cases at handover meetings on a voluntary basis and this can be used towards a CBD within their portfolio. ST and CTs are paired with a named consultant for a six-month placement, enabling continuity of supervision across clinics and theatre sessions. Opportunities also exist to work with other consultants through clinical allocations, providing exposure to a range of supervisory styles and expertise. In theatre, consultants create supportive opportunities for real-time feedback and discussion. The trainers also note that a SCOTGEM student is currently undertaking an audit focused on communication.

Foundation: The FYs reported limited opportunities to receive regular feedback due to the availability of surgical senior staff. As a result, feedback was described as infrequent, making it difficult for FYs to gauge its quality, consistency and developmental value.

Core & ST: All RDiTs reported that they get regular feedback and handover is often used for this. The consultants will also be in contact throughout the day and give feedback. The feedback that is given is constructive and meaningful, whilst also used to develop themselves.

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

Trainers: Not formally asked, however the presentation discussion highlighted that the trainers seek feedback on improvements implemented. The trainers note various audits for the induction and handover processes.

All RDiTs: Not formally asked, however through the visit and from the PVQ, there are opportunities to escalate any issues to the consultants and there are forums for RDiTs to raise any concerns.

2.12 Culture & undermining (R3.3)

Trainers: The trainers report that they acknowledge that reports of undermining behaviour can be delayed and therefore promote early reporting through confidential one-to-one discussions and established supervisory processes. A clear zero-tolerance approach is communicated at induction, and all residents are encouraged to raise concerns promptly to enable timely support and intervention. Where concerns are identified, they are addressed quickly using established escalation processes, with a focus on supporting those involved and maintaining a positive learning environment.

Foundation: The FYs described the department as welcoming and supportive, with a strong sense of teamwork within the relatively small cohort. FY2s were identified as a valuable first point of contact, and positive working relationships had been established with FYs and nursing colleagues. Handover sessions were also used as educational opportunities, with FYs occasionally invited to present case-based discussions. However, a negative experience at handover was described, where intensive questioning caused significant distress and detracted from the educational value of the exercise. Some reported that interactions with specialty doctors could at times feel abrupt and were uncertain about the appropriate routes for raising concerns.

While these experiences were not reported as widespread, it was felt that clearer mechanisms for feedback and support would be beneficial**.**

Core & ST: Both CT & STs report that the clinical team and senior colleagues are extremely supportive. They are given the opportunity to train, with some reporting that this is the best experience of training to date. The RDiTs have not witnessed or experienced undermining or bullying behaviour. All answered that they would know who to contact about these types of behaviours and feel that these concerns would be taken seriously and addressed appropriately.

2.13 Workload/ Rota (1.7, 1.12, 2.19)

Trainers: The trainers report that there are currently no rota gaps, and staffing levels include sufficient FYs to support two dedicated float shifts. Those allocated to these shifts are available to provide cover for unexpected absences or service pressures. When not required for cover, they are encouraged to take advantage of additional learning opportunities, including attendance in theatre. In relation to OOH, a FY1 forms part of the HAN team and works closely alongside other team members. A medical advanced nurse practitioner (ANP) provides overnight cover for medical boarders. It is recognised that challenges can arise if there is an ANP vacancy overnight; however, these occurrences are infrequent and FY1s are aware of the need to escalate concerns promptly when they arise. The trainers also note that the rota has been redesigned by successive cohorts over the past three years. This process begins approximately two months prior to changeover, allowing the incoming cohort to benefit from a rota that has been reviewed and refined by their predecessors, with implementation occurring when the new rotation begins.

Foundation: The FYs reported that rota intensity varied depending on where they entered the eight-week rota cycle, with some working significantly more weekends than others. This was perceived as inequitable and could be particularly challenging for those with long commutes. Concerns were also raised about staffing levels between 6pm and 8.30pm, when a single FY may provide surgical ward cover. It was felt that workload, fatigue and limited time for documentation during these periods could impact decision-making and patient safety. It was reported that clinical and administrative demands frequently resulted in RDiTs staying beyond their scheduled hours.

Core & ST: The RDiTs reported that although there were rota gaps at the beginning of the placement, these did not have a significant impact on their training experience. All noted that they do not feel that the rota impacts their well-being and allows for a balance of training.

2.14 Handover (R1.14)

Trainers: The trainers reported that the formal handovers take place at 8:00am and 8:00pm, with the on-call registrar responsible for updating the shared electronic handover document. The handover sheet includes outstanding tasks, elective patients, and medical boarders. Following feedback, the night FY1 shift was changed from 9:00pm to 8:00pm to enable attendance at handover and improve continuity of care. Medical boarders are reviewed by the on-call team prior to handover to ensure appropriate oversight and clear transfer of information. Surgical outliers occasionally occur, but the team works closely with bed managers to return patients to a surgical ward as soon as possible. Handover does serve as an educational opportunity. Interesting or complex cases are discussed with consultants, who use these cases to explore clinical decision-making, patient pathways, and key learning points with the resident doctors.

Foundation: FYs reported that the weekday evening handover is scheduled for 8pm but is often delayed due to the Hospital at Night team arriving later, resulting in some uncertainty regarding clinical cover during this period. Similar challenges were reported at weekends. The FYs are aware of a quality improvement project is currently underway to strengthen and formalise the morning handover process. It was reported that FYs are encouraged to utilise the SBAR framework. The staggered start and finish times were reported to make handover more challenging. The educational value of handover was reported to vary and was largely dependent on the senior staff present and the opportunities available for clinical discussion and learning.

Core & ST: The RDiTs reported that during the day, the on-call team utilised a shared electronic handover list containing key patient information, including responsible consultant, date of admission and ongoing management plans. The document is continuously updated and formed the basis of team communication and patient tracking. Morning handovers were consultant-led, while overnight handovers involved the on-call registrar, FY and HAN. Handover was reported to be safe, effective and fit for purpose. The shared handover system was described as easy to use, well supported by IT infrastructure, and accessible via a large display screen to facilitate team discussions and maintain situational awareness. Handover was also viewed as a valuable

educational opportunity, allowing discussion of clinical cases. FYs are encouraged to participate actively in handover discussions.

2.15 Educational Resources (R1.19)

All: Not formally asked as no concerns in survey or PVQ.

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

All: Not formally asked, as no concerns in survey or PVQ.

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

All: Not formally asked, as no concerns in surveys or PVQ.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Consultant trainers described themselves as approachable and would encourage RDiTs to seek support both formally and informally if they felt required to raise any concerns. The trainers also note that they have regular wellbeing checks and have strong trainer-resident doctor relationships. As it is a small unit, they feel that they get to know their residents well. The trainers state that the department have a good MDT and work closely with the resus team. Close communications with that team ensures that any FY1 involved in a resus is followed up with to ensure their wellbeing is fine. This line of communications also allows the team to see what is required to be escalated to InPhase reporting. Involving FYs in Morbidity and Mortality meetings (M&M) allows FYs to understand and feedback any concerns. The trainers also note they have delivered an education session called “the second victim,” which demonstrates the human side of a consultant and how any complications can also affect senior members of staff.

Foundation: All FYs note they feel they would be able to approach and team member and their concerns would be escalated appropriately.

Core & ST: All RDiTs reported that if they had any concerns these would be raised with the consultant in the first instance. Escalation pathways were clear, relevant staff were easy to contact; therefore, they would be addressed efficiently and in a timely manner.

2.19 Patient safety (R1.2)

Trainers: The trainers report that service pressures are most commonly associated with capacity issues within the Surgical Assessment Unit (SAU), particularly when delays in patient flow limit bed availability. Patients are sometimes assessed in the Emergency Department, which the trainers acknowledge is not always an ideal environment for clinical assessment. Its stated that a surgical ANP will triage the patient, then the ST3+ will be the decision maker, whilst the FY1 may clerk the patient in. However, they work closely with Emergency Department colleagues and are aware of escalation processes to maintain patient safety.

Foundation: FYs highlighted ongoing challenges within the SSU and noted that a significant number of medical boarder patients are cared for within the department. Despite this, the FYs reported that medical teams were accessible and did not express concerns regarding the overall care of these patients. Some patient safety concerns were raised regarding patients whose care crosses specialty boundaries, particularly when elective patients become acutely unwell. FY described uncertainty around which team held primary responsibility for patient management, leading to complex communication and escalation processes, and this can occur at least twice a month in the unit.

Core & ST: The RDiTs reported that they had no concerns about the safety or quality of care for their patients. They recognised that managing boarded patients was challenging across the hospital and could be particularly difficult for FYs. It's highlighted that the SAU is part of the in-patient service, which can be overwhelming at times due to bed space. The STs note that there is an ongoing QI project to improve the service in this area. It is also stated that the ED were supportive when RDiTs needed to attend.

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

Trainers: Adverse events are reported through the InPhase reporting system. When a report involves a RDiT, trainers are notified and they arrange a one-to-one discussion to review the

incident, address any concerns, and support reflective learning. The trainers would also encourage resident doctor to complete reflective entries following significant events where appropriate. It is highlighted that there are monthly M&M meetings RDiTs are encouraged to submit cases, particularly morbidity cases, and FY doctors are supported to present at meetings. Outcomes and learning points are recorded, and any required changes to practice or processes are implemented and shared with the wider team.

Foundation: Not formally asked due to time constraints.

Core & ST: All reported that they would feel well supported by their consultant team and the Clinical Lead following an adverse event. All were aware of the incident reporting process and understood how to escalate and report patient safety concerns.

2.21 Other

No other concerns highlighted to the visiting team.

3. Summary

Patient Safety:

- No significant patient safety concerns were identified; however, RDiTs highlighted several potential risks associated with current service pressures.
- Bed pressures within the Surgical Assessment Unit continue to result in patients being managed across multiple locations, which can impact continuity of care despite good support from A&E.
- Ongoing concerns were raised regarding the management of medical boarders, with a need for a clear and consistent escalation process.
- Greater clarity is required around consultant ownership and discharge responsibility, particularly for patients in the short-stay unit and those with complex medical or palliative care needs.

Positive aspects of the visit:

- The senior team was described as highly supportive, and the department was viewed as engaged, proactive, and committed to continuous improvement, with a significant amount of quality improvement activity evident.

- Induction was praised as one of the best experiences Resident Doctors in Training (RDiT) had received at both hospital and departmental level. However, it was noted that all RDiTs do not consistently receive the departmental handbook during induction. The panel would encourage the department to consider incorporating a physical hospital tour for Foundation RDiTs as part of the induction programme to help orientate new starters.
- Core and Higher RDiTs described their training experience as excellent, highlighting the department's ability to accommodate individual training needs, including endoscopy and theatre exposure.
- The Friday meetings were commended as an effective way to coordinate training opportunities, maintain flexibility, and ensure RDiTs know who is available and how to access support.
- Further areas of positive training will be shared in the full visit report.
- The panel were impressed with the engagement from the senior team and wish to commend them on this.

Less positive aspects of the visit

- Clinical Supervision: Foundation RDiTs continue to report difficulties accessing timely senior support, with variable availability and approachability of supervisors. Further work is required to improve consistency of supervision.
- Non-Educational Tasks: Foundation RDiTs spend significant time on administrative duties, particularly note transcription and interpreting post-operative instructions, reducing time available for training and often extending the working day.
- Rota: While CTs and STs were satisfied with rota arrangements, the FYs felt the 8-week cycle can be demanding, particularly when combined with non-educational workload pressures.
- Handover: Handover processes are generally effective; however, improvements are needed around the timeliness of the 8pm Hospital at Night handover, HAN involvement in morning handovers, and handover of downstream patients.
- Patient Flow and Ownership: Ongoing challenges relating to bed pressures, management of medical boarders, and clarity of consultant ownership for some patients were highlighted. Clear escalation pathways and defined clinical responsibility would help improve continuity of care.

Is a revisit required?	**Yes**	**No**	**Dependent on outcome of action plan review**

4. Areas of Good Practice

Ref	Item	Action
4.1	The trainer team demonstrates a strong commitment to education and well-being.	n/a
4.2	Excellent training opportunities for Core and ST RDiTs, supported by sustained pairing with a named supervisor.	n/a
4.3	A high level of engagement with the Core and STs for the rota, enabling greater coverage of opportunities and experience	n/a
4.4	The buddying of FYs and higher RDiTs for QI project is commendable.	n/a

5. Areas for Improvement

Areas for Improvement are not explicitly linked to GMC standards but are shared to encourage ongoing improvement and excellence within the training environment. The Deanery do not require any further information in regard to these items.

Ref	Item	Action
5.1	Induction – The departmental handbook should be distributed to all grades before starting in post. It was also noted a tour for the FYs would further improve their experience.	The induction booklet or online equivalent should be sent to all grades of trainees before commencing in post.

6. Requirements – Issues to be addressed.

Ref	Issue	By When	Resident doctor cohort in scope
6.1	There must be robust arrangements in place to ensure the tracking of all boarded patients. In addition, for boarded patients, there needs to be clarity which Consultant and clinical care team are responsible, how often patients are reviewed and what the escalation policy is.	29th June 2027	All
6.2	Measures must be implemented to address the (ongoing) patient safety concerns described in this report. Specifically in relation to SAU and medical boarders.	29th June 2027	All
6.3	Clinical supervision must be available at all times. Those providing clinical supervision must be supportive of RDiTs who seek their help and must never leave trainees dealing with issues beyond their competence.	29th June 2027	FY
6.4	Tasks that do not support educational and professional development and that compromise access to formal learning opportunities for all cohorts of doctors should be reduced.	29th June 2027	FY
6.5	The Rota pattern must be reviewed with the FYs who are on the rota to identify ways to address their concerns.	29th June 2027	FY
6.6	Handover arrangements must be reviewed, especially between on call and day teams.	29th June 2027	All