Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	4th March 2026	Level(s)	Foundation & Specialty
Type of visit	Triggered (virtual)	Hospital	Raigmore Hospital
Specialty(s)	Trauma & Orthopaedics	Board	NHS Highland

Visit Panel	
Dr Fiona Drimmie	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Fiona Cameron	Foundation School Director
Dr Gemma McGrory	Training Programme Director
Dr Laura Mulligan	Trainee Representative
Mr Bill Rogerson	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine, Surgery, Occupational Medicine & AICEM
Lead Dean/Director	Professor Adam Hill
Deputy Dean/Director	Mr Alastair Murray
Associate Postgraduate Deans	Dr Reem Al-Soufi, Dr Fiona Drimmie, Dr Kerry Haddow & Dr Alan McKenzie
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Ms Vhari Macdonald
Unit/Site Information	
Trainers in attendance	8
Resident Doctors in attendance	(7-F1, 6-ST)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	1	Medical Director	1	Other	26
Report approved by: Dr Fiona Drimmie (Visit Lead) Professor Adam Hill (Lead Dean Director)										

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.

Following ongoing Quality Engagement Meetings, review and triangulation of available data, including the GMC National Training Survey and NES Scottish Trainee Survey, a Deanery visit was arranged to Trauma & Orthopaedics at Raigmore Hospital. This visit was requested following Quality Engagement Meetings and the return of Foundation resident doctors in training (RDITs) to the department from August 2025.

Issues highlighted include:

NTS

All Trainee – Green Flag – Workload.

GPST – All Grey.

ST – Pink Flag – Handover. Green Flag – Workload.

STS

All Trainee January 2025 – Red Flags – Clinical Supervision, Educational Environment & Teaching, Handover.

All Trainee June 2025 - All White.

Foundation January 2025 – Red Flags - Educational Environment & Teaching, Handover, Workload.

Foundation June 2025 – All Yellow.

GPST January 2025 – All Grey.

GPST June 2025 – All Grey.

ST January 2025 – Pink Flag – Clinical Supervision. Red Flag – Handover.

ST January 2025 – All White.

Department Presentation:

The visit commenced with Mr Gerard Cousins, Mr Farrukh Gillani and Ms Ana Paosinho delivering informative presentations. These provided detailed information including structure of the department along with challenges, implemented improvements, how these will be sustained over future training blocks and feedback from Foundation RDITs.

2.1 Induction (R1.13):

Trainer: Trainers reported comprehensive inductions to the hospital and department. There is a structured agenda for departmental induction which consists of various presentations including the Training Programme Director (TPD) and ortho-geriatrics. There is also a session on the portfolio, plaster room demonstration and a walk round of the wards and hospital for those new to the hospital. Sessions are recorded and a handbook and standard operating procedures are disseminated prior to commencing in post. A QR code has been created to allow Foundation resident doctors to confirm read receipts. They noted that induction evolves each year in response to feedback with plans in place from recent feedback to provide clarification of roles and responsibilities for Foundation resident doctors in the handbook. Finally, they noted that ST1s are not expected to hold the bleep within their first 2 weeks in post to allow a settling in period.

F1: F1s received both hospital and departmental inductions. They would find it useful to receive more detailed information on ortho-geriatrics and clarification on escalation policies which they believe are not clear within the handbook. They noted that a physical ward induction tour was scheduled to take place however did not happen which resulted in them feeling a little lost for the first few days in post.

ST: STs received good quality inductions to the hospital and department which included a tour.

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

Trainer: Trainers reported that regional teaching for registrars takes place in Aberdeen once a month with cover provided by staff grades. On a few occasions they have been unable to attend due to lack of cover however this is unusual and does not happen regularly. They noted that departmental teaching is run by a resident doctor in Aberdeen with consultant support with sessions are mapped to the curriculum.

F1: F1s receive one-hour of departmental teaching per week which is delivered by a registrar. They noted that a 12-week programme was to be created where F1s would sign-up and be allocated a slot to provide a 10-minute presentation which would then be supplemented with more detailed teaching from the registrar, however this did not happen. They would find it useful if departmental teaching was standardised and appropriate to their level of training. Practical sessions would also be appreciated. They confirmed being able to attend most of their core teaching. There are times when they are unable to attend teaching which can be due to completing discharge letters or attending clinical emergencies.

ST: STs reported that teaching takes place within the daily morning trauma meetings. There is also bi-weekly registrar teaching in the evening. They have no concerns in attending regional teaching which takes place in Aberdeen.

2.3 Study Leave (R3.12)

Trainer: Trainers confirmed that they are not aware of any study leave requests being declined. On occasion there may be clashes with the rota but in general all requests are approved. They noted challenges for F1s in taking study leave and attending teaching due to budget issues.

F1: F1s were not aware they could request study leave for Taster sessions in block 2.

ST: STs reported no concerns 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)

Trainer: Trainers reported all registrars are allocated an educational supervisor for the training year with clinical supervisors changing after 6 months. Juniors are allocated to a day of the week they provided an example which includes Monday – trauma list, Tuesday – fracture, Wednesday – ward support, Thursday – on-call. ST3+ are sub-specialty based they meet with their TPD to map out how they will achieve covering all sub-specialties. 6-weeks prior to changeover learning needs for the post are discussed, agreed and tailored to individual needs. Foundation resident doctors are allocated supervisors and training sessions have been held to ensure trainers are aware of the Foundation portfolio and curriculum. Trainers noted being well supported to fulfil their supervisory roles. They receive regular course updates from the deanery, undertake the yearly appraisal process and ensure recognition of trainer status is kept up to date by submitting evidence regularly through their portfolio. They reported receiving robust information beforehand on any resident doctor requiring additional support.

F1: F1s have designated educational supervisor and clinical supervisors who they meet 2-3 times within the post and have set educational objectives. One supervisor was highlighted as not familiar with navigating the portfolio.

ST: STs have a designated educational supervisor who they meet regularly informally with 3 formal meetings in each block which they find constructive and beneficial.

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)

Trainer: Trainers commented that name badges help differentiate between the different training grades. Due to being a relatively small department resident doctors become familiar with the team quickly, it is expected any new members of staff would introduce themselves and highlight their role. They noted that information on who to contact for support forms part of induction and is also detailed within the handbook. Escalation for F1s is to the clinical development fellow (CDF) or ward support then the on-call consultant. There is a weekday huddle which highlights the ward support and on-call consultant. They are not aware of any instances where resident doctors have been expected to cope with problems out with their level of competence and encourage them to raise any concerns immediately with their supervisor or the on-call consultant. There are clear guidelines on seeking consent within the handbook and support is always available from a registrar or consultant should anyone feel uncomfortable in doing so.

F1: F1s are aware who is providing clinical supervision during the day and out of hours (OOH). They believe escalation OOH is clear and simple and is to the on-call registrar or consultant. In hours however it takes a while to know who to contact with varying escalation pathways of registrar to consultant or CDF to registrar to consultant. In addition, there is also the ortho-geriatric team. A large part of their role is dealing with complex medical situations, and they noted challenges in receiving appropriate support and feedback particularly for these patients however find most registrars helpful when asked. They noted approachability of consultants varies. They are provided with excellent support from the ortho-geriatric and medical teams who they feel comfortable asking questions to and are provided with feedback.

ST: STs reported no concerns regarding supervision and are aware of who to contact during the day and OOH. They do not believe they have had to cope with issues beyond their level of competence. They noted that supervisors provide excellent support and are accessible and approachable.

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

Trainer: Trainers reported excellent training opportunities available to resident doctors within the hospital. They noted that oncology is an area where experience must be provided by another training site however are confident that the majority will experience no problems in obtaining a satisfactory number of learning experiences for their annual review of competence progression (ARCP).

F1: F1s reported no concerns in achieving learning objectives for the post and believe the post has allowed them to develop skills and competence in managing acutely unwell patients however learning is limited and little feedback is provided unless sought. They believe that a high percentage of their working day is spent carrying out tasks of little of no benefit to their education or training. They commented that during the day they do not review patients however carry out all the jobs. OOH they see all patients and do the jobs. Most areas do not provide opportunities for learning.

ST: STs reported they have access to all opportunities available to them in the department and have no concerns regarding any competence or learning outcomes. They believe the post allows them to develop skills and competences in managing the acutely unwell patient. They noted that the junior STs provide ward support and noted good support from the medical team and ortho-geriatric team for the more complex patients. They believe around 10-20% of their time is spent carrying out duties that are of little benefit to their education or training.

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

Trainer: Covered in section 2.6.

F1: F1s reported no difficulties in obtaining workplace-based assessments. Registrars are supportive in providing assessments however they rarely receive assessments from consultants.

ST: STs reported no difficulties in obtaining workplace-based assessments.

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

Trainer/ST: Not asked, no concerns raised in pre-visit questionnaire.

F1: F1s commented on interacting with nurses and allied health professionals daily and have good working relationships. They noted that there is no ward pharmacist and would find it useful to have pharmacist input in prescribing.

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

Trainer: Trainers reported quality improvement (QI) and audit projects are very well supported within the department and they foster an environment where QI is part of day-to-day work. They noted that this has led to resident doctors presenting at international conferences and receiving awards for submissions. They described a yearly afternoon brainstorming session to gather a bank of potential projects with input from resident doctors. The department also have a designated research lead.

F1: F1s reported good opportunities to get involved with QI and audit with all F1s in attendance confirming undertaking a project in this block.

ST: STs reported good opportunities to get involved with QI and audit projects.

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

Trainer: Trainers stated that regular informal feedback is provided along with formal feedback in the form of start, mid and end block reviews. The trauma meeting is also a useful place for registrars to gain feedback as they regularly present cases. Formal feedback for F1s is gathered through the placement supervision group (PSG) and team assessment of behaviour (TAB) forms.

F1: F1s noted receiving very little feedback on their clinical decisions during the day and out of hours. If they require feedback, then they must seek it or look back through patient notes. They did note being provided with good feedback from the medical registrar. They noted good working relationships with T&O registrars however most often the advice provided is to contact the medical registrar. They also noted seeking support from the ward support however that individual can be anywhere within the hospital and are generally tasked with looking after boarders. Feedback and advice can vary depending on the individual and what they are comfortable providing.

ST: STs reported several points for review of clinical decisions during the day and OOH and opportunities to receive feedback. They believe that morning trauma meetings are good places to receive constructive and meaningful feedback. They noted that there is no toxicity, blame or demeaning behaviours in the hospital.

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

Trainer: Trainers reported that the department has a small cohort of resident doctors and believe it is relatively easy to see if there are any issues with the training provided. They are confident resident doctors are comfortable in providing feedback if required and offer an open-door policy.

F1: F1s stated that they provide feedback to consultants regarding the quality of training when they check-in and ask. They are happy to provide feedback and feel listened to however are unsure to what extent this feedback is actioned.

ST: STs reported that trainers are very supportive as it is a small department you know colleagues well. They consider there to be a positive feedback loop for training.

2.12 Culture & undermining (R3.3)

Trainer: Trainers reported a zero tolerance for bullying and undermining in the department which is reinforced within induction sessions. Any complaints are taken very seriously and escalated through appropriate channels. They are aware of comments via the 2024/25 Scottish Training Survey and note a conscious effort from consultants to address this, be vigilant and share how things could be done better. Resident doctors are encouraged to flag any concerns early to allow matters to be addressed appropriately. On occasion there has been a need to change supervisors due to relationships not working this is done in a constructive and professional manner.

F1: F1s reported the clinical team and seniors on the ward are supportive however when a patient is unwell and concerns are raised regarding patient safety, they can feel shutdown and dismissed with failure to recognise the issue from an F1s perspective. An example was provided where several medical emergency calls were made which resulted in an F1 having discussions with different departments they considered this to be inappropriate and were provided with no orthopaedic support. Comments were also made regarding poor communication where consultants can look to blame. They commented that most consultants are nice however would not be comfortable in raising any concerns regarding bullying or undermining with the department as they may not be listened to.

ST: STs raised no concerns regarding bullying or undermining behaviours. They noted hearing of people who don't get on with each other and of occasional disagreements which can be uncomfortable however the department is extremely supportive. They are aware of how to raise concerns.

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

Trainer: Trainers reported no gaps in the rota at Foundation level however there is a GPST gap with some shifts being covered by the STs. Adhoc cover is provided for short term sickness however this can be challenging to manage. To ensure no one is pulled from clinic or theatre the ward support may have to provide this cover however this is rare. They commented that F1s coming into post from medicine can struggle with the structure and patient management of a surgical department.

F1: F1s reported receiving the rota late with changes still being made once they started in post. There were also problems with arranging annual leave and cover of short-term sick leave however noted drastic changes and improvements since the rota co-ordinator took over in mid-December. They commented on receiving insight days where they can gain experience in different areas which they find very useful.

ST: STs confirmed no gaps in the rota and appropriate cover provided to allow attendance at learning events. They confirmed that the rota accommodates specific learning opportunities and includes clinics and managing on-call take. There is also time within the working day for QI.

2.14 Handover (R1.14)

Trainer: Trainers reported robust handover arrangements and described the daily morning trauma meeting and ward rounds as a good place for providing educational opportunities. There is also a daily 9am huddle and evening handover which focus on clinical aspects.

F1: F1s reported that the trauma meeting takes place at 8am daily followed by a handover for 3A where all patients are discussed with nursing staff, occupational therapy and the on-call consultant. There is also a handover at 10pm to the advanced nurse practitioners (ANPs). They noted coming in 15 minutes early to receive a handover from the ANPs and hand back to the ANPs at the end of shift. Handovers are not used as learning opportunities unless you are presenting at the morning trauma meeting.

ST: STs commented that the morning trauma meeting is consultant lead, covers anything that has happened overnight and is used as a learning opportunity. Ward rounds are led by the ward charge nurse and go through all patients highlighting any issues. They believe there is an agreed structure to handover where a patient list which the F1s go through and highlight any outstanding jobs.

2.15 Educational Resources (R1.19)

Trainer: Trainers noted that there is a seminar room and orthopaedic library which offers additional space for learning. They are aware of challenges with IT.

F1/ST: Resident doctors noted that there are computers available there is also a dedicated orthopaedic library used for the trauma meetings and formal educational opportunities. There is also a registrar room.

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

Trainers: Trainers reported that resident doctors are signposted to pastoral support and formal support routes within induction should they be struggling with any aspect of their training. Support is also available from TPDs and the deanery if required. They also find interim ARCPs formative in highlighting possible educational needs where targeted support can be provided.

F1: F1s believe that support would be available to them if they were struggling with any aspects of the job or their health.

ST: STs reported that the formal route for support should they be struggling with any aspects of the job is through their supervisors who they would be comfortable talking to. They believe reasonable adjustments would be made for anyone requiring them.

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

Trainer: Not asked due to time constraints.

F1/ST: Resident doctors reported being aware of resident doctor's meetings where they feel comfortable in raising any concerns they may have regarding their training or education.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked due to time constraints.

F1/ST: Resident doctors reported that they are comfortable in raising concerns regarding patient safety and believe they would be addressed appropriately.

2.19 Patient safety (R1.2)

Trainer: Trainers highlighted that physiotherapy and ortho-geriatrics were areas of concern however additional support is now available via the ward support. F1s are allocated to look after boarders however are well supported and will review with the ward support or CDF. They are also aware of escalation pathways if required.

F1: F1s reported that there is a process for boarding patients. They would have no concerns if a family member were admitted for orthopaedic problems however comorbidities that fall out with the remit of the ortho-geriatrics team would be of concern.

ST: STs stated that they would have no concerns if a friend or family member were to be admitted to the department. They have no concerns regarding the system for boarding patients and the care they receive.

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

Trainer: Trainers stated that there are monthly morbidity and mortality (M&M) and audit meetings where resident doctors are given the opportunity to present. Adverse incidents can also be reported via the datix reporting system where they look for themes to enhance learning from incidents.

F1: F1s confirmed they are aware of the datix reporting system for adverse incidents and would also escalate to the consultant and registrar responsible for the patient. Although they have no direct experience, they believe appropriate support would be provided by registrars but are unsure regarding what support would be provided by consultants.

ST: STs reported that they are aware of the datix reporting system for adverse incident and of robust discussion and learning from such events through M&M. They are confident they would be well supported by consultants if they were involved in an adverse incident and consider the department to be a no blame supportive environment.

2.21 Other

Overall Satisfaction Scores: n/a.

3. Summary

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

The panel noted excellent engagement from the department and management team in supporting the visit and acknowledge the significant amount of work put into improving the training environment. The panel also noted positive comments relating to induction, regional teaching, quality improvement, handover, escalation and supervision. Areas for improvements were noted as departmental induction, departmental teaching, feedback and raising concerns. 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.

Positive aspects of the visit:

- Excellent engagement from the department and site management teams in supporting the visit.
- Recognition of the work and engagement of the Trainers who are working extremely hard to make sustainable improvements and are committed to providing a good training environment.
- Resident doctors described robust induction to the hospital and department which are supported by comprehensive induction booklets. Trainers also noted planned improvements to F1 induction and updates to the induction booklet to include further information on roles and responsibilities.
- Resident doctors noted being able to regularly attend regional/deanery teaching with STs having allocated time within the rota.
- Resident doctors described being actively involved in Quality Improvement/research.
- A number of handovers were noted as taking place all of which are working well and include consultant presence within at least 2.
- STs noted feeling very well supported with bespoke learning plans tailored to their individual training needs. Excellent exposure to operative activity and teaching opportunities.
- F1s reported being able to take insight days which they find useful.
- Excellent support provided by the Ortho-geriatric team.
- Escalation pathways are well documented within induction booklets and work well OOH however they are more complex during the day and can be confusing during the first few weeks in post.
- Resident doctors reported good levels of supervision during the day and OOH with supportive, approachable and accessible seniors/consultants.

Less positive aspects of the visit:

- F1s reported that the planned ward tour did not take place as part of induction.
- Despite extensively improved support for F1s they can still feel out of their depth regarding feedback on day-to-day decision making and management plans.
- Although F1s can attend departmental teaching it somewhat lacks structure appropriate to their level of training.
- F1s reported they have no interaction with pharmacists which they would find beneficial especially when prescribing for patients on multiple medications.

- F1s noted not always feeling comfortable in raising concerns and when doing so may feel listened to however receive no feedback and don't know if action has happened in relation to their concern.

4. Areas of Good Practice

Ref	Item	Action
4.1	Provision of insight days for F1s.	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	F1s reported that the planned ward tour did not take place as part of induction.	
5.2	Although F1s can attend departmental teaching it somewhat lacks structure appropriate to their level of training.	
5.3	F1s reported they have no interaction with pharmacists which they would find beneficial especially when prescribing for patients on multiple medications.	
5.4	F1s noted not always feeling comfortable in raising concerns and when doing so may feel listened to however receive no feedback and don't know if action has happened in relation to their concern.	
5.5	A process for providing feedback to Foundation resident doctors in training on their input to the management of acute cases must be established. This should also support provision of WPBAs	

6. Requirements - Issues to be Addressed

Nil