Public Services Delivery
Scotland

NHS SCOTLAND

SCOTLAND DEANERY QUALITY MANAGEMENT: VISIT REPORT

Date of visit	25th June 2026	**Level(s)**	Foundation, Core, Specialty
Type of visit	Triggered Visit	**Hospital**	Dr Gray's Hospital
Specialty(s)	General Surgery & Trauma & Orthopaedics	**Board**	NHS Grampian

Visit Panel	
Dr Fiona Drimmie	Visit Chair - Associate Postgraduate Dean (Quality)
Dr Alastair Murray	Deputy Postgraduate Dean
Dr Alan Stockman	Training Programme Director
Dr Sophie Johnston	Resident Doctor Representative
Ms Sarah Summers	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Gaynor Macfarlane	Quality Improvement Administrator
Mr Steven Binnie	Lay Representative (Observer)

Specialty Group Information	
Specialty Group	Foundation, Surgery
Lead Dean/Director	Dr Greg Jones
Deputy Dean/Director	Dr 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	3
Resident Doctors in attendance	4 (2-FY1, 1-CT, 1-ST)

Feedback session: Managers in attendance	Chief Executive	0	DME	1	ADME	1	Medical Director	0	Other	8
Report approved by Lead Visitor / Lead Dean	Dr Fiona Drimmie Dr Greg Jones									

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 for Trauma & Orthopaedics and the return of Foundation resident doctors to Trauma & Orthopaedics through a base post in General Surgery. Along with review and triangulation of available data, including the GMC National Training Survey and NES Scottish Trainee Survey for General Surgery. A combined Deanery visit is being arranged to General Surgery and Trauma & Orthopaedics at Dr Gray's Hospital.

General Surgery NTS 2025/26

All Trainee – Red Flag – Clinical Supervision, Feedback, Induction, Overall Satisfaction, Supportive Environment. Pink Flag – Adequate Experience, Clinical Supervision Out of Hours, Feedback, Workload.

Core Surgical Training – All Grey.

F1 Surgery – All Trainee – Red Flag – Clinical Supervision, Induction, Overall Satisfaction, Supportive Environment. Pink Flag – Adequate Experience, Clinical Supervision Out of Hours.

ST – All Grey.

General Surgery STS 2025/26

Bottom 2%

Core Surgical Training – All Grey.

All Trainee – Red Flags – Clinical Supervision, Discrimination, Educational Environment & Teaching, Equality & Inclusivity, Handover, Induction. Pink Flag – Team Culture.

Foundation – Red Flags – Discrimination, Educational Environment & Teaching, Induction. Pink Flag – Clinical Supervision, Induction.

Core – Aggregated Pink Flags – Handover, Wellbeing & Support. Aggregated Red Flag – Rest Facilities.

ST – All Grey.
At the pre-visit teleconference the visit panel agreed that the focus of the visit should be around the areas highlighted in the survey data, and the pre-visit questionnaire.

At the visit the panel met with 2 out of the 7 FY1s in post therefore the report includes feedback from a further 2 FY1s provided within the pre-visit questionnaire. A separate session was held with the CT/ST on the 21st July 2026.

Department Presentation:

The visit commenced with Ms Petra Haller, Lead Clinician Orthopaedics & Ms Laura Nicol Associate Director of Medical Education and Consultant Surgeon delivering an informative presentation to the panel. This focused on key priorities which were noted as integration of the Trauma and Orthopaedic (T&O) service within NHS Grampian, structure and staffing configuration in the departments, concerns previously raised within survey data, improvement work undertaken and next steps.

2.1 Induction (R1.13):

Trainers: Trainers reported that departmental induction prepares Resident Doctors in Training (RDiTs) effectively for both daytime and out-of-hours working. Bespoke induction sessions are provided for those unable to attend the main programme. T&O induction for FY1s is now included as a programmed activity within Ms Haller's job plan and was delivered in December 2025 and April 2026. Areas for improvement have been identified, with enhancements planned ahead of the August changeover. A Microsoft Teams channel is available to all RDiTs and contains key departmental information. In addition, a T&O Foundation handbook and a General Surgery middle grade induction handbook are available which is regularly updated by RDiTs.

FY1/CT/ST: FY1s reported that the hospital induction provided in August was of a good standard and included presentations from a range of clinical departments. While they received an induction to T&O, they were unable to recall a specific departmental induction for General Surgery. They also noted that some of the information available online is outdated and would benefit from review and updating. CT and ST resident doctors received adequate induction to both departments which included a tour and

induction booklets. Feedback has been provided to Ms Nicol on how T&O induction could be improved.

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

Trainers: Trainers reported that efforts are made to ensure regional and national teaching is bleep free and are confident that RDiTs can attend most of their scheduled teaching when on shift. Local teaching opportunities include weekly departmental sessions on Wednesdays, rotating between General Surgery, Radiology and T&O; monthly TBQR meetings where RDiTs present cases; 6 weekly regional TBQR meetings; monthly Morbidity and Mortality (M&M) meetings; and monthly hospital shared learning sessions. Attendance at these sessions was reported to be good.

FY1/CT/ST: Resident doctors reported receiving 1–2 hours of locally delivered teaching each week, including weekly meetings, alternating General Surgery, T&O and Radiology teaching sessions. There are also some dedicated FY1 teaching sessions. They are generally able to attend regional teaching with non-attendance most commonly due to night shifts, on-call shifts, annual leave, or zero days. FY1s suggested that face-to-face teaching sessions delivered at Dr Gray's could be recorded to support those unable to attend. They also reported not being invited to some teaching sessions delivered in Aberdeen but were able to access recordings online. Difficulties were also noted in attending in-person core teaching sessions due to distance with most held in Glasgow or Edinburgh.

2.3 Study Leave (R3.12)

Trainers: Trainers reported that FY1 development days are built into the rota and can be used to pursue individual learning interests. They were not aware of any requests being made for taster sessions within this post.

FY1/CT/ST: Resident doctors reported no concerns regarding study leave. FY1s reported good opportunities built into the rota for development and to support taster sessions.

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

Trainers: Trainers reported that educational supervisors are allocated by the Foundation Team, with supervisory responsibilities shared across the three trainers within the department. Formal meetings are held with RDiTs at the start, midpoint and end of each placement. As a small department, trainers also have regular day-to-day contact with RDiTs. Trainers have protected time within their job plans for supervisory duties, with locum staff supporting the provision of clinical supervision. Information regarding RDiTs requiring additional support filters through from undergraduate, Foundation Programme Directors (FPDs) and Training Programme Directors (TPDs). Ms Nicol, in her dual role as Associate Director of Medical Education, also plays an active role in coordinating any additional support required.

FY1/CT/ST: FY1s reported meeting formally with their educational supervisors at the start and end of the placement, which they found beneficial. These meetings included discussions about their learning objectives for the post. CT and ST resident doctors work with educational supervisors regularly and meet formally throughout the block which they find useful. They described consultants as approachable and reported regular informal interactions with them on the ward. They stated they would feel comfortable raising concerns with senior staff if required.

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: Trainers reported that clear escalation pathways for clinical supervision are in place both during the day and out of hours which are highlighted during induction and reinforced regularly. Awareness of these pathways is discussed during educational supervisor meetings, with FY1s asked to confirm they know how to access support and advice when required. For surgical issues, the escalation pathway is FY1 to middle-grade doctor to consultant, while medical concerns are escalated via the medical on-call team. Critical care support is typically accessed through the middle-grade anaesthetic doctor rather than directly by FY1. Ms Haller also emphasises her availability as a source of support. Trainers confirmed that middle-grade doctors obtain consent only for procedures they are competent to perform. While obtaining consent is not expected of FY1s, they are welcome to observe the process where appropriate.

FY1/CT/ST: Resident doctors reported that they were aware of clinical supervision arrangements and know who to contact for support both during the day and out of hours. They described cross-covering multiple specialties out of hours and highlighted occasional difficulties accessing appropriate support in a timely manner after 17:00 and overnight. Difficulties were noted in covering T&O on-call due to a lack of knowledge to deal with these patients. FY1s raised concerns regarding inconsistent levels of support from a small number of middle-grade doctors, particularly where experience levels have varied. Examples were provided where middle-grade doctors appeared uncertain about management decisions or were unable to offer practical assistance. An example was provided of escalating a complex catheterisation issue after unsuccessful attempts by both medical and surgical teams; however, the middle-grade doctor on call had limited experience with the procedure, and the FY1 was unaware of the outcome following patient transfer. Resident doctors are comfortable escalating issues to consultants when required and generally did not feel expected to manage problems beyond their level of competence. Although middle-grade doctors were not always immediately available on the ward, FY1s confirmed they could be contacted when working in the Surgical Ambulatory Clinic (SAC) or theatre.

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

Trainers: Trainers reported a good understanding of the curricula for the different levels of RDiTs. Regular updates on Foundation training requirements are provided by Dr Louise Millar, Foundation Programme Director, and through ongoing medical education meetings with colleagues in Aberdeen. They are confident that RDiTs can achieve adequate exposure to both theatre and outpatient clinic activity, and that all Foundation curriculum competencies can be met across the two departments. Any concerns regarding RDiTs progression are managed through close collaboration between supervisors, the TPD and Ms Nicol, who attends Annual Review of Competence Progression (ARCP) panels and supports RDiTs in her role as Associate Director of Medical Education. Trainers noted that General Surgery placements are offered up to ST3 level only, recognising that the department cannot provide the full range of subspecialty experience required for ST4 level and above.

FY1/CT/ST: FY1s are confident that the post supports progression towards Foundation curriculum competencies. They reported that development days are built into the rota, enabling attendance at theatre sessions, outpatient clinics and other educational opportunities. They noted attending an interesting session in the plaster room. They felt that the General Surgery component of the post provides valuable experience in assessing and managing acutely unwell patients. In contrast, they felt that a post based solely in T&O would offer fewer opportunities to develop these skills due to the department's non acute focus and lower patient turnover. They noted that many patients undergo surgery in Aberdeen before being repatriated to Dr Gray's Hospital for ongoing care, where FY1s work closely with physiotherapists and occupational therapists and are involved in discharge planning. They also reported that responsibility for managing patients who deteriorate medically while under T&O care typically falls to them. The ongoing care of rehabilitation patients has limited senior input. There is some ortho geriatric input, but this happens without including them which limits the FY1s opportunity to learn from seniors about medical management/comorbidity or rehabilitation medicine. CT and ST resident doctors confirmed good opportunities to attend clinics and theatre. They described good elective operative experience and independently running the SAC and noted good consultant support if required. They noted that is can be hectic when covering both SAC and the emergency department.

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

Trainers: Trainers reported no concerns in RDiTs being able to achieve required assessments when in post.

FY1/CT/ST: FY1s reported that they found it harder to complete assessments in this post compared to Medicine. There is reasonable opportunity in surgery but less in T&O. As this is their final block, they had completed most assessments required for ARCP in previous blocks. CT and ST resident doctors reported no concerns in completing workplace-based assessments which are fair and consistent.

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

Trainers: Not asked due to time constraints.

FY1/CT/ST: Resident doctors reported limited opportunities to learn with other health care professionals. They noted attending the hospital wide shared learning event which is open to all and departmental TBQRs which can involve dieticians and pharmacists. FY1s recall being invited to attend a dressing teaching session however were unable to attend due to an emergency on the ward.

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

Trainers: Trainers reported that there are good opportunities for RDiTs to participate in quality improvement and audit activity. This is discussed during initial meetings with educational supervisors and RDiTs are allocated an audit or quality improvement project. They are also encouraged to present their work at grand rounds, hospital shared learning events, departmental teaching sessions and TBQR meetings.

FY1/CT/ST: Resident doctors reported good opportunities to be involved with quality improvement projects or audits in General Surgery with opportunities to present at hospital wide shared learning.

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

Trainers: Trainers reported that feedback is provided regularly through day-to-day interactions. Formal feedback is typically given following significant clinical events or when a RDiTs wish to reflect on an aspect of patient care. Positive feedback is also provided, often through email, to recognise good practice.

FY1/CT/ST: FY1 reported receiving regular low level informal feedback on their clinical decision-making. CT and ST resident doctors similarly described receiving routine feedback during handovers where patient management is discussed. However, they felt that comparable feedback is not consistently available within T&O and reported often acting as an intermediary between the emergency department and T&O during handover. CT and ST resident doctors also considered the T&O induction insufficient in preparation for out-of-hours responsibilities, noting that much of their learning occurred through experience in post. They frequently seek advice from middle-grade colleagues regarding patient management and escalation pathways. Feedback on these concerns and potential areas for improvement has been provided to Ms Nicol.

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

Trainers: Trainers reported that educational supervisors obtain feedback from RDiTs during end-of-placement meetings, enabling improvements to be identified and implemented for subsequent blocks. In addition, regular meetings are held between RDiTs, clinical leads and departmental managers to provide ongoing opportunities for feedback and engagement.

FY1/CT/ST: Resident doctors reported providing feedback to trainers and the management team on the quality of their training at resident doctor drop-in sessions and the National Training Survey/Scottish Training Survey. There are also opportunities within TBQR monthly meetings and during meetings with educational supervisor.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that improving the team culture remains an ongoing priority. Work is ongoing with a wellbeing facilitator assigned to the department, and most trainers have completed active bystander training. Significant efforts are being made to promote an open and supportive environment, encouraging RDiTs to raise concerns promptly and confidently within a safe setting. It was reported that RDiTs with a career intention of T&O may receive additional constructive feedback.

FY1/CT/ST: Resident doctors reported a good team culture in the departments. They have not experienced or witnessed behaviours of bullying or undermining.

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

Trainers: Trainers reported that CT and ST RDiTs have limited outpatient clinic exposure due to the focus on operative training. However, experience gained within SAC is considered sufficient to meet curriculum requirements. They confirmed that there are currently no rota gaps and were unaware of any rota-related issues adversely affecting RDiT wellbeing, aside from the commuting demands experienced by some based in Aberdeen. Trainers also acknowledged concerns regarding accommodation in Elgin. Clear processes are in place for managing sickness absence, and RDiTs are regularly reassured that they should not feel under pressure to attend work when unwell.

FY1/CT/ST: FY1s reported no current rota gaps and did not feel that the rota has adversely affected their wellbeing. Time allocated to T&O is spread throughout the placement in blocks of 2-4 days, with FY1s providing additional support to the General Surgery team when T&O duties are complete due to the higher workload on the surgical ward. CT and ST resident doctors described a shift pattern comprising day (08:00-17:00), late (12:00-20:00) and night (20:00-08:30) duties. Staffing includes two middle-grade doctors covering a combination of on-call, elective, SAC and ward support responsibilities. While day and night shifts were generally considered manageable when adequately staffed, RDiTs highlighted the absence of a formal handover at the start of late shifts. They felt that introducing a structured handover would help ensure the late shift person knows what is going on in the wards.

2.14 Handover (R1.14)

Trainers: Trainers reported that handover processes provide good continuity of care and appropriate surgical oversight. They acknowledged that the T&O handover process requires further refinement, particularly regarding the content of the handover sheet. Efforts are focused on achieving an appropriate balance between providing sufficient clinical information and maintaining a manageable document. RDiTs are discouraged from adding detailed medical issues to the T&O handover sheet to prevent it becoming overly complex. General Surgery utilises a similar handover sheet containing relevant information on current admissions, supported by a job book. FY1s use the handover documentation to record updates.

FY1/CT/ST: FY1s reported that handovers provide safe continuity of care for surgical patients and new admissions. However, they do not believe there is adequate handover of medical issues affecting surgical patients. They commented on being instructed not to add medical information to the handover sheet which as FY1s they would find useful to have included however they do understand the need to keep the handover sheet concise. They described actively updating the handover list during night shifts to minimise workload for the daytime FY1s, who generally only need to add details of new admissions. They believe handover is used to relay information rather than being used as a learning opportunity although there are opportunities to review scans and ask questions. CT and ST resident doctors reported formal morning handover as taking place where all new overnight admissions are discussed. They noted using handover sheets in both general surgery and T&O.

Middle grades are responsible for providing their own handover which they believe works well. They find handover in T&O informal and unstructured and believe that FY1s are unhappy with the lack of planning and structure.

2.15 Educational Resources (R1.19)

Trainers: Trainers reported adequate resources to support RDiTs learning. They highlighted the librarian who is very knowledgeable and runs the knowledge network and the clinical skills area which provides a lot of teaching and simulation training for undergraduates.

FY1/CT/ST: Resident doctors described educational facilities and resources as inadequate with one working computer available in the doctor's mess. FY1s also noted no opportunity to receive simulation training although are aware that regular simulation sessions take place for undergraduates and they can be asked to help deliver these.

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 support for RDiTs experiencing difficulties is clearly signposted during educational supervisor induction meetings. RDiTs are provided with information on available support, including pastoral support within the department, Occupational Health services, and the deanery's Training Development and Wellbeing Service (TDWS).

FY1/CT/ST: FY1s could not recall being informed what support was available to them should they be struggling with any aspects of the job or their health. CT and ST resident doctors believe that support would be provide if they were struggling with any aspect of the job or their health however have not had to request such support.

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

Trainers/FY1/CT/ST: Incorporated in section 2.11.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that RDiTs are encouraged to escalate any immediate patient safety concerns to the on-call consultant. Alternatively, concerns can be raised with their educational supervisor or another trusted colleague. RDiTs also have the opportunity to discuss concerns through regular RDiT forum meetings.

FY1: FY1s reported raising concerns with the management team which they believe were promptly and adequately addressed with positive changed noted.

2.19 Patient safety (R1.2)

Trainers: Trainers stated that RDiTs are encouraged to use the datix system to report any patient safety concerns. There are no safety huddles which take place for boarded patients.

FY1/CT/ST: FY1s stated that they would have no concerns about a friend or family member receiving care within General Surgery however CT and ST resident doctors believe that the surgical department do their best however due to lack of infrastructure and resources they rely on tertiary services to provide care. Resident doctors are aware of the Datix system for reporting patient safety concerns and noted that nursing safety huddles take place throughout the day, although they do not routinely attend these meetings. FY1s expressed some concern in relation to orthopaedics due to the model of care and need for transfers. They are also not directly informed of back transfers from Aberdeen and can at times find patients in the ward who they were unaware of. This can delay an appropriate review or cause work for the OOH person which could have been done during the day shift.

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

Trainers: Trainers reported that adverse incidents are reported through the Datix system. Incidents assigned a review level of 1 or 2 are discussed at M&M meetings and shared TBQR meetings. Feedback is provided to individuals in a supportive environment rather than within group settings. CT and ST RDiTs are encouraged to present cases at M&M meetings and contribute to identifying learning points and service improvements. Where an RDiT is involved in a Datix incident, feedback is provided by the Associate Director of Medical Education.

FY1/CT/ST: Resident doctors stated that they have not been involved in an adverse incident however believe that appropriate support would be provided.

2.21 Other

Overall Satisfaction Scores: n/a.

3. Summary

Is a revisit required?	**Yes**	**No**	

The panel thanked the departments and medical education team for supporting the visit. The panel heard of a positive team culture in General Surgery and ongoing work with team culture in T&O. Positive comments were noted relating to August induction, regional and departmental teaching, educational and clinical supervision, quality improvement, feedback and team culture. Areas for improvements were noted as departmental induction, regional teaching, adequate experience, educational resource and handover. 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:

- FY1s reported attending the majority of their regional and departmental teaching sessions.
- FY1s reported good opportunities for development with allocated days in the rota to support attending clinics and theatre sessions or to undertake tasters.
- FY1s confirmed having designated educational supervisors who they meet regularly and are always aware of who is providing clinical supervision during the day and out of hours
- FY1s noted good opportunities to be involved with quality improvement projects.
- FY1s described receiving regular useful informal on the job feedback, particularly within general surgery.
- FY1s reported a good team culture with supportive and approachable consultants.
- F1s reported feeling comfortable in raising concerns regarding patient safety with senior colleagues or the management team.

Less positive aspects of the visit:

- The visit team were only able to meet with 2 FY1s. An additional session will be arranged prior to August changeover where a reduced panel will meet with the CT and ST RDiTs.
- Continued reliance on locum cover within the middle grade rota remains a concern with Dr Gray's Hospital. The responsiveness of locum staff to escalation of surgical concerns is variable and can leave FY1 doctors feeling unsupported.
- FY1s describe delay in informing them of the readmission of surgical patients from Aberdeen Royal Infirmary. This increases out of hours workload and means patients may not be included in handover.
- FY1s reported attending thorough induction in August however could not recall formal departmental induction in blocks 2 or 3 or receiving the surgical induction handbook.
- Although FY1s reported attending most of their regional teaching session however noted no opportunity to catch up on the face-to-face sessions delivered in Dr Gray's as these are not on TEAMS and therefore not recorded. Recording or these would allow catch-up if unable to attend due to nights or zero days.
- FY1s noted limited educational experience in trauma and orthopaedics and would benefit from further learning about rehabilitation and medicine. Ortho-geriatric support is available however they do not engage with FY1s in trauma and orthopaedics which would help their experience and training.
- FY1s commented on inadequate office space and computers.
- Handover arrangements require further consideration with regards to handover documentation and how this can best meet the needs of various team members.

4. Areas of Good Practice

Ref	Item	Action
4.1	FY1s reported good opportunities for development with allocated days in the rota to support attending clinics and theatre sessions or to undertake tasters.	nil

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	Continue to strengthen and secure strong clear governance processes to mitigate varying skill level on middle grade rota if service is to be expanded.	
5.2	FY1s reported attending most of their regional teaching session however noted no opportunity to catch up on the face-to-face sessions delivered in Dr Gray's as these are not on TEAMS and therefore not recorded. Recording or these would allow catch-up if unable to attend due to nights or zero days.	Explore if it is feasible to record teaching session and make these available online.
5.3	FY1s noted limited educational experience in trauma and orthopaedics and would benefit from further learning about rehabilitation and medicine. Ortho-geriatric support is available however they do not engage with FY1s in trauma and orthopaedics which would help their experience and training.	Consider how to integrate learning relating to rehabilitation and medicine into the teaching programme for FY1s. Consider options for better communication from the Ortho-geriatric team to FY1s.
5.4	Handover arrangements require further consideration with regards to handover documentation and how this can best meet the needs of various team members.	Consider how to include medical information within handover sheets.

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	Handover of care of patients transferred from Aberdeen Royal Infirmary to T&O at Dr Gray's Hospital must be introduced to support safe continuity of care and to ensure unwell patients are identified and prioritised.		
6.2	Departmental induction must be provided at each rotation to highlight day to day expectations and ensure RDiTs are aware of all of their roles and responsibilities in both T&O and General Surgery. The induction booklet or online equivalent should update regularly and be sent to all grades of RDiTs before commencing in post.		
6.3	The Board must provide sufficient IT resources to enable doctors in training to fulfil their duties at work efficiently and to support their learning needs.		