Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	20th June 2025	**Level(s)**	Foundation
Type of visit	Enhanced Monitoring Re-visit	**Hospital**	University Hospital Monklands
Specialty(s)	General Surgery	**Board**	NHS Lanarkshire

Visit Panel	
Dr Kerry Haddow	Visit Chair – Associate Postgraduate Dean (Quality)
Dr Fiona Drimmie	Associate Postgraduate Dean (Quality) & Foundation Programme Director
Ms Kate Bowden	General Medical Council
Ms Christina Hayes	General Medical Council (Observer)
Ms Sarah Chiodetto	Lay Representative
Mrs Jennifer Duncan	Quality Improvement Manager
In Attendance	
Mrs Susan Muir	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine, Surgery, Occupational Medicine & AICEM
Lead Dean/Director	Professor Adam Hill
Deputy Dean/Director	Dr Alastair Murray
Associate Postgraduate Deans	Dr Reem Al-Soufi, Dr Fiona Drimmie, Dr Kerry Haddow, Dr Alan McKenzie & Mr Phil Walmsley
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Ms Vhari Macdonald
Unit/Site Information	
Trainers in attendance	3
Resident Doctors in attendance	8 (F1 - 7, F2 – 1)

Feedback session: Managers in attendance	Chief Executive	0	DME	0	ADME	1	Medical Director	1	Other	16

Report approved by Lead Visitor / Lead Dean	Dr Kerry Haddow Professor Adam Hill

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.

General Surgery at the University Hospital Monklands has been under the GMC Enhanced Monitoring process since 2023. Following on from the previous visit held on the 23rd July 2024, SMART Objectives Meeting held on the 31st October and Action Plan Review Meeting held on the 18th March 2025, a Deanery enhanced monitoring revisit was scheduled.

The visit identified 5 requirements:

- Educational supervision structures must be formalised, and regular face-to-face meetings held with trainees.
- Provide evidence around the clinical supervision and escalation arrangements and trainees' perceptions of how readily available access to senior support is.
- Those providing clinical supervision must be supportive of trainees who seek their help and must never leave trainees dealing with issues beyond their competence or 'comfort zone'.
- 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.
- Relationships within the Surgical department must be improved. All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.

Survey data August 2024 – July 2025:

NTS

All Trainees – Pink Flag - Adequate Experience, Clinical Supervision, Clinical Supervision Out of Hours.

Core CST – Grey Flag.

F1 Surgery – Pink Flag – Adequate Experience, Clinical Supervision.

STS

STS Priority List.

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

Core CST – All Grey.

All Trainee – Red Flag – Clinical Supervision, Discrimination, Educational Environment & Teaching. Pink Flag - Equality & Inclusivity, Induction.

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.

Department Presentation:

The visit commenced with Mr Asad Toor, General Surgery Consultant delivering an informative presentation. This provided detailed information including the journey of the department since 2021, challenges faced, improvements made and actions taken against requirements from last visit and enhanced monitoring themes. A particular highlight in the presentation was the use of the Cappuccini test audit tool to evaluate escalation pathways.

2.1 Induction (R1.13):

Trainers: Trainers reported that for some F1s induction starts within the undergraduate preparation for practice programme which aims to ease the transition from student to F1. F1s in block 1 also undertake a shadowing week prior to commencing in post which allows them the opportunity to observe their roles and responsibilities and experience the different shift patterns. They noted 3

formal induction sessions as taking place over the training year which are led by a urologist and include the hospital and department. Should an individual be unable to attend the induction lead will pick this up on an individual basis. They noted that most of the elements of day-to-day working are gathered when doing the job. Finally, there is an induction handbook which is currently under revision with a view to simplifying the content and ensuring it's specific to Foundation, this will be relaunched in August 2025.

F1/F2: FYs confirmed receiving hospital and departmental inductions. They did not receive an induction handbook and commented on relying heavily on those who had previously completed the post for day-to-day guidance. They noted that induction is carried out by a consultant urologist and believe it would be useful for a General Surgery consultant to be involved. Within the pre-visit questionnaire they suggested the following improvements:

- Induction handbook which is distributed to all.
- Induction to take place in the morning of first day in post.
- Ward tour.
- Role cards.
- Information relating to the role of the F1 and F2 on the ward and at ward rounds, CPOD, receiving areas, on-call, referral pathways that require specialty input and handover times and location.

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

Trainers: Trainers reported one-hour of on-site regional teaching for F1s per week which is bleep free. F2 regional teaching is incorporated into the rota. They can also attend Grand Rounds on a Wednesday and departmental teaching on a Friday. Unfortunately, it is not possible for all FYs to attend all sessions due to cover required on the ward and are therefore asked to co-ordinate attendance between themselves and the ward support doctor. All FYs are allocated a slot within the departmental teaching programme to undertake a presentation which provides them with the opportunity to request a workplace-based assessment. After feedback was received on the timing of departmental teaching and difficulties in attending due to a clash with ward rounds it was agreed to revise the time and hold teaching slightly later.

F1/F2: FYs reported that regional teaching takes place on a Thursday which is protected and bleep free, they are encouraged to attend and noted being able to attend 80-90% of sessions. Departmental

teaching takes place on a Friday which is of good quality and noted that they are timetabled to present once when in post. Concerns were noted that on occasion ward rounds are still underway when teaching begins despite recent adjustments to timings.

2.3 Study Leave (R3.12)

Trainers: Not asked, no concerns raised by F2s in the pre-visit questionnaire.

F2: Within the pre-visit questionnaire F2s reported no problems in requesting or taking study leave and find the system easy to use.

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

Trainers: Trainers noted that educational supervisors are allocated to FYs for the training year and clinical supervisors are allocated per block. They confirmed that one supervisor has a primary base at Wishaw however is on site regularly, there are no supervisors who are permanently off site. They feel well supported in their roles as supervisors with appropriate time in job plans.

F1/F2: FYs reported being allocated a clinical and educational supervisor who they meet twice while in post.

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 advised that day to day supervision is provided by clinical supervisors. They noted that morning meetings involve the on-call team, CPOD team, SACU team and all FYs. There is an additional 3pm board round on ward 4 where they review all patients and test result before going to see new admissions or those who have been flagged. There is a robust escalation policy in place and a formal handover checklist which holds details of those on-call each day. This is reviewed daily and updated to reflect any changes. Consultant also carry DECT phones with numbers shared with all. They are confident FYs are aware of escalation pathways which is F1 to junior middle grade then senior middle grade or consultant. They believe good levels of support are always available and consultants encourage FYs to contact them at any time. Support is also available through the ward support doctor which has moved from a single person to being part of the junior middle grade rota which has been well received. They acknowledged that FYs may find weekends to be more

challenging as staffing levels are different however there has been an increase to 3 FYs providing cover for General Surgery and Urology. Escalation pathways are the same for the weekend. They are only aware of one incident where an F2 felt they could have been provided with more support on their SACU week at the beginning of the post which is easily resolvable.

F1/F2: FYs confirmed they are aware of who to contact for clinical supervision both during the day and out of hours details of which are added to the daily handover sheet. They noted that they rarely contact the consultant and would first seek support from a middle grade or registrar who were noted as providing excellent support. It can be understandably more difficult to get support when seniors are in theatre. They believe that they have had to cope with problems beyond their level of competence, but this has been rare. An example was provided relating to a prescribing error which was logged through the datix system, it was believed better support could have been provided during and after the incident. They noted that they can feel under pressure and on occasion have to deal with patients alone should someone become medically unwell out of hours as it can be difficult to get surgeons to take responsibility, with advice provided to contact the medical registrar. This however is not unique to this hospital and the medical registrar is helpful.

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

Trainers: Trainers confirmed being familiar with the Foundation curriculum. They commented that although there is no requirement for F1s to attend clinic or theatre if they have a particular interest, this can be facilitated. There is flexibility in the rota for F2s to accommodate swaps for the out of hours (OOH) component to support attendance at a particular clinic or theatre session. They described a nightshift where there is a junior middle grade, senior middle grade and F2 where the F2 will follow the on-call urologist which provides good training opportunities. They are not aware of any specific competencies or learning outcomes that FYs would find difficult to obtain in post. They commented that the question of balance between training and what is perceived as non-educational tasks is difficult to answer. The hospital has efficient processes and good services which they believe reduce the amount of non-educational tasks however there will always be times where FYs are required to undertake tasks such as bloods and venflons as this is part of the job.

F1/F2: FYs commented that it can be difficult to obtain workplace-based assessments in post. Most noted receiving no assessments from consultants with registrars and the medical registrar providing

any assessments in post. They are provided with opportunities to attend outpatient clinics if they wish to undertake these however there are minimal opportunities to clerk or attend theatre. They commented that the nature of the post makes them good at multi-tasking and prioritising. There are days when they will not interact with patients and can spend the day doing jobs and reviewing results on the computer. They can be asked to review a patient if they are sick and would follow escalation pathways if necessary. They do not believe there is any direct supervision on the ward, they are aware of the ward support doctor however they are not always visible and are often not on the ward in the afternoon. They are also not always aware of who the ward support doctor is, they are not included on the handover sheet and do not carry a phone or bleep.

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

Trainers: Trainers believe there are sufficient training opportunities in the department to allow FYs to easily achieve minimum assessment requirements. Most assessments are completed by registrars with consultants contributing to multisource feedback (MSF) and placement supervision group (PSG). FYs also can ticket for an assessment when presenting at Friday departmental teaching.

F1/F2: Included in section 2.6.

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

Trainers: Trainers reported nurse practitioners and SACU nurses are invited to attend Thursday and Friday teaching sessions. They also advised that there are opportunities for muti-professional learning at hospital wide morbidity and mortality meetings (M&M).

F1/F2: FYs reported that there are opportunities to learn with other health professionals. They have received teaching from the pharmacist, advanced nurse practitioners and the HEPMA team are also involved in induction. They have not attended any teaching sessions so far with the nursing team.

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

Trainers: Trainers reported there is a good system in place to support FYs in undertaking a quality improvement (QI) project. There is designated consultant with the role of QI co-ordinator who keeps

an overview of projects and is happy to help provide support. There are regular QI workshops and drop-in sessions where guidance on projects can be sought. FYs are also encouraged to present a project at the QI roadshow.

F1/F2: FYs reported good opportunities to engage with a quality improvement project. They noted a list of topics being sent in blocks 1 and 2.

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

Trainers: Trainers stated feedback is provided regularly to FYs on their clinical management plans. Clinical issues can be discussed during ward rounds and time can be arranged to discuss more sensitive issues. Consultants also return to the ward to check-in with FYs every afternoon. F2's are also present at the morning handover where they can discuss any issues. The department have a strong network of junior and senior middle grades who provide excellent support.

F1/F2: FYs reported rarely receiving feedback on their clinical decisions during the day and out of hours. They commented that they are often on the ward alone therefore there is little opportunity to receive feedback. They noted receiving assessments and good teaching opportunities within Urology.

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

Trainers: Not asked, no concerns raised in the pre-visit questionnaire.

F1/F2: Within the pre-visit questionnaire FYs noted having various opportunities to provide feedback to trainers and the management team on the quality of their training such as monthly medical meetings, readily available seniors who are happy to discuss any issues, department teaching, M&M meetings or through clinical supervisors/foundation programme director.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported a greatly improved team culture and consider the department to be relaxed and safe. There have been some new consultant appointments made recently who have come on board with some new ideas which are welcomed. Should an FY have any concerns relating to bullying or undermining when in post they are advised to raise this through their educational

supervisor, the chief resident, clinical lead or clinical director. There are also regular meetings held with the deputy director of medical education and clinical lead where they encourage an open forum. They are not aware of any current issues relating to team culture or undermining.

F1/F2: FYs reported no concerns regarding bullying or undermining behaviours in the department. A few examples were provided where an FY felt undermined, this was escalated however they were unsure what action was taken. There was also an occasion where a consultant was rude to the night team however, they believe this was an isolated incident. They do not consider the team culture to be negative or hostile and believe they are treated well by seniors.

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

Trainers: Trainers noted that any gaps in the rota have been filled with long-term locums. They do not anticipate any changes to staffing and confirmed health board funding would continue for any locum posts. There is also the possibility that the department will be allocated an additional FY and middle grade in the next training year, however this is yet to be confirmed.

F1/F2: FYs raised no concerns with the rota which they commented supports them taking breaks. There are no aspects that have compromised their training, education or wellbeing.

2.14 Handover (R1.14)

Trainers: Trainers described a robust and structured handover process in General Surgery which provides learning opportunities. They are confident handover arrangements provide safe continuity of care and ensures all patients are discussed. A handover sheet has also been implemented and is working well it holds details of who is on-call each day which is reiterated within the meeting. They described a typical handover as beginning with a review of any unwell patients followed by an update from the night team on any issues from overnight before going onto any new patients. They acknowledge that Urology handover may not be as structured as General Surgery. Urology handover takes place after the General Surgery handover with the junior middle grade attending in person. They are unsure if this includes the FY in Urology.

F1/F2: FYs reported General Surgery handover as taking place at 8.30am in a designated room. They described a typical handover meeting as including a printed handover sheet, introductions including grade and role, confirmation of any rota gaps or staffing issues, run through of patients and new admissions, check that do not resuscitate orders are in place where appropriate, night team update on unwell patients, confirmation of escalation pathways and finally there is an opportunity to raise any issues. They noted often being quizzed on who they should escalate to. Consultants and registrars return to the ward at 3pm and check test results, jobs to be done and patients that require to be seen. There is also an 8.30pm handover to the evening team which follows a similar format. Finally, there is a Urology handover after the 8.30am General Surgery handover from the night to day team. They do not consider any of the handovers to provide learning opportunities, they noted occasionally reviewing scans.

2.15 Educational Resources (R1.19)

Trainers: Not asked, no concerns raised in the pre-visit questionnaire.

F1/F2: FYs noted in the pre-visit questionnaire that resources were adequate.

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 noted that the main source of support on the ward is provided by the ward support doctor with more serious issues supported by clinical and educational supervisors. Any concerns regarding wellness or for anyone struggling with the job is through the lead clinician who will follow up.

F1/F2: FYs believe that support would be available to them if they were struggling with the job or their health and would be comfortable in discussing with their educational supervisor rather than a person within the department as they do not know them very well.

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/F1/F2: Not asked, no concerns raised in the pre-visit questionnaire.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that FYs are encouraged to raise concerns relating to patient safety with clinical and educational supervisors, clinical lead, chief resident or clinical director. They also offer an open-door policy to all.

F1/F2: FYs stated that they would raise any concerns relating to patient safety with their educational supervisor. They believe that patient safety can be affected in the surgical high dependency unit (HDU) at the weekend which often involves patients who are post-op and acutely unwell. Due to staffing, workload and volume of patients it can be difficult to see all patients over the weekend. They noted escalating these concerns and have been advised that remediations are in progress.

2.19 Patient safety (R1.2)

Trainers: Trainers believe the department provides a safe environment for FYs and patients. Most problems are raised and addressed within the structured handover. There are also ward rounds all of which involve the FYs. They believe individual workload has reduced due to increased staffing and that all patients are seen in a timely manner.

F1/F2: Within the pre-visit questionnaire FYs raised no concerns relating to patient safety. Concerns relating to surgical HDU over the weekend were noted in section 2.18.

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

Trainers: Trainers confirmed that the datix system is used to report adverse incidents. There is also monthly M&M meetings and hospital wide M&Ms which provide learning opportunities. They commented that bigger cases are easier to flag and take through the process and smaller issues can be more challenging however they try to remain consistent with process and ensure learning from all. FYs are invited to attend monthly departmental M&M meetings.

F1/F2: FYs confirmed they are aware of the datix reporting system for adverse incidents and confirmed being invited to regular M&M meetings.

2.21 Other

Overall Satisfaction Scores taken from pre-visit questionnaire:

F1/F2 – 6.8/10

13 F1s (5-block 2 and 8-block 3) and 3 F2s (1-block 2 and 2-block 3).

3. Summary

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

The panel commended the engagement of the site and medical education team in supporting the visit and noted the considerable efforts made to improve training. Areas for improvement were noted as induction, clinical supervision at weekends in HDU, adequate experience assessments, feedback and urology handover. Positive comments related to teaching, supervision, quality improvement, rota, handover and adverse incident reporting. 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. The site will also be considered for de-escalation from Enhanced Monitoring.

Positive aspects of the visit:

- Excellent engagement from the Medical Education team and site management teams in supporting the visit. Recognition of efforts and engagement to make sustainable improvements.
- Accessible and bleep free regional teaching with FYs able to attend most sessions.
- Departmental teaching is taking place regularly with FYs timetabled to present at, at least one session. The panel encourage work to continue as there are still some timings issues with ward rounds running into teaching sessions.
- Clinical supervision and escalation policies are working well with constant reminders of who to call when and why. A particular highlight was noted in the use of the Cappuccini Test.
- Good opportunities for engagement in a quality improvement project with a list of audits available and support provided.
- Approachable consultants. FYs felt treated with respect.
- FYs praised the rota which is set-up in a way they tend not to miss breaks.

- The ward support doctor role is well received but change from a single ward doctor to a rolling rota were noticeable. The panel would encourage the department to add the ward doctor's details to the handover sheet and to develop a roles and responsibilities document to ensure equitable support is provided.
- The structure of handover and the handover document are working well. Trainers consider handover to provide good learning opportunities.
- The addition of a 3pm consultant board round has been well received.
- FYs are aware of Datix reporting system and learning from incidents. FYs are invited to attend M&M meetings.

Less positive aspects of the visit:

- Departmental induction is provided by the rota co-ordinator who is a urologist, this would benefit from general surgery input and the development of an induction handbook. The panel would encourage the department to utilise the current group of FYs to input into the handbook as they reported seeking support and clarification regularly from previous cohorts of FYs.
- Concerns were noted relating to clinical supervision and patient safety on weekends in surgical HDU where there is only one F1 responsible for covering all of surgery.
- Concerns were noted relating to WPBA where FYs received no assessments from consultants. Despite this FYs confirmed that they were able to meet minimum assessment requirements.
- There is a disconnect in what consultants believe is formal feedback and what FYs perceive as formal feedback. The panel encourage consultants to engage with the completion of WPBAs and opportunities within departmental teaching to help with this.
- Urology handover is less structured and would benefit from review and formalising.

4. Areas of Good Practice

Ref	Item	Action
4.1	Clinical supervision and escalation policies are working well with constant reminders of who to call when and why. A particular highlight was noted in the use of the Cappuccini Test.	

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	Departmental induction is provided by the rota co-ordinator who is a urologist, this would benefit from general surgery input and the necessary induction handbook.	
5.2	There is a disconnect in what consultants believe is formal feedback and what FYs perceive as formal feedback. The panel encourage consultants to engage with the completion of WPBAs and opportunities within departmental teaching to help with this.	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
6.1	A written programme wide induction booklet should be produced for all new trainees to the specialty.	December 2025	F1, F2
6.2	Trainees must be provided with clearly identified seniors who are providing them with support during out of hours cover within surgical HDU.	Immediate	F1, F2
6.3	There must be senior support, including from consultants/recognised trainers to enable doctors in training to complete sufficient WPBAs/SLEs to satisfy the needs of their curriculum.	Immediate	F1, F2

6.4	All handovers within Urology must be more structured and more robust with written or electronic documentation.	December 2025	F1, F2