

Scotland Deanery
Quality Management Visit Report

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

Visit Panel	
Dr Alastair Campbell	Visit Chair – Deputy Lead Dean/Director
Dr Cieran McKiernan	Associate Postgraduate Dean (Quality)
Dr Karen Rose	Foundation Programme Director
Mr Eddie Kelly	Lay Representative
Miss Fiona Paterson	Quality Improvement Manager
In Attendance	
Miss Claire Rolfe	Quality Improvement Administrator

Specialty Group Information	
Specialty Group	Medicine, Surgery, Occupational Medicine & AICEM
Lead Dean/Director	Dr Greg Jones
Deputy Lead Dean/Director	Mr Alastair Murray
Associate Postgraduate Deans	Dr Reem Al-Soufi, Dr Fiona Drimmie & Dr Kerry Haddow
Quality Improvement Manager(s)	Mrs Jennifer Duncan & Ms Vhari Macdonald
Unit/Site Information	
Trainers in attendance	✓
Resident Doctors in attendance	FY✓ Core✓ ST✓

Feedback session: Managers in attendance	Chief Executive	0	DME	✓	ADME	✓	Medical Director	✓	Other	✓
Report approved by Lead Visitor / Lead Dean		09/07/2026								

1. Principal issues arising from pre-visit review:

Following local intelligence, it was agreed to conduct a triggered visit to all Trauma & Orthopaedic (T&O) departments within West of Scotland.

A summary of the discussions has been compiled under the headings in section 2 below. This report is compiled with direct reference to the GMC's Promoting Excellence - Standards for Medical Education and Training. Each section heading below includes numeric reference to specific requirements listed within the standards.

Department Presentation: The site delivered a presentation outlining areas of good practice, areas for improvement, and ongoing quality improvement work. Further detail is provided in the report below.

2.1 Induction (R1.13):

Trainers: The induction process is well organised and delivered four times a year. Preparation starts in advance with clear communications sent out, including key departmental documents such as the "Ortho Bible" which details how the department runs and clinical pathways. Educational Supervisor allocations are included. On the day, consultants attend the hospital session in the morning followed by a departmental session. The programme includes a welcome presentation, lunch, hospital tour and training on the trauma system.

FY & Core ST1-2: RDiTs told us they didn't receive a structured induction. They reported key areas such as on-call expectations and ward responsibilities were not covered and they largely learned on the job. There was also limited opportunity to develop practical skills through the induction process, such as joint manipulation and cast application which left some FY's feeling unprepared for on-call duties. There is a general understanding that RDiTs should seek advice when unsure and registrars are described as approachable and supportive in practice.

ST3-8 – All received departmental induction and rated it very good with no suggestions to improve.

Hospital Induction

FY, Core & ST1-2: Most FYs received hospital induction however some reported they were unable to attend due to on call shift.

ST3-8: Some RDiTs reported delays to log in details and security access

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

Trainers: Teaching takes place weekly at lunchtime. It is flexible and adapts to meet the needs of each group with a focus on supporting workplace-based assessments and covering key clinical management. Sessions are protected with RDiTs encouraged to hand over their pager to ward staff. However, attendance can be challenging.

FY: Informal learning is variable and depends on clinical activity. Some teaching occurs during trauma meetings in the mornings and occasionally while on-call with the registrar. However, there is no teaching reported on the wards and formal departmental teaching is infrequent. RDiTs told us that much of their knowledge has not been gained through departmental teaching. They reported no issues in accessing their mandatory FY teaching sessions.

Core & ST1-2: There is weekly RDiT-led teaching scheduled. However, they reported that delivery is inconsistent and often pitched below the expected level. Sessions were described as poorly organised, with low attendance. There is no formal consultant-led teaching in place.

Access to core teaching programme days can be difficult due to day-to-day service commitments. Time is usually given to watch sessions back instead. Core RDiTs do not have access to the regional T&O teaching programme in the West of Scotland, while run-through T&O RDiTs at ST1–2 level are able to attend. This disparity has resulted in concerns regarding equity of educational opportunity.

ST: RDiTs reported that there is weekly structured, registrar-led teaching focused on key orthopaedic conditions. However, all felt that teaching could be improved and would value more consultant-led, senior-focused dedicated sessions.

2.3 Study Leave (R3.12) Not asked, no concerns raised in PVQ

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

Trainers: For specialty training (ST) doctors in the region, the Training Programme Director works with the Specialty Training Committee to allocate consultant trainers, based on specialty interests, level of competence, and any additional support needs. Foundation & Core doctors are allocated both an Educational Supervisor and a Clinical Supervisor for each placement.

RDiT: RDITs reported no issues with formal supervision. They were allocated an educational supervisor and met with them at the start and mid-point of the post, with end-of-placement meetings planned.

2.5 Clinical supervision (day to day) (R1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 2.14, 4.1, 4.6)

Trainers: Remote working across Monklands and Hairmyres remains the most significant challenge for the service. Middle grade/Tier 2 cover is provided on site until midnight, with the registrar available from home thereafter. A proposal has been submitted to increase middle grade staffing through a two-tier rota, restoring numbers to pre-restructure levels and strengthening cover. There is a second consultant on call to address simultaneous emergencies across sites.

FY: Overall RDITs reported feeling well supported within the department. There are three orthopaedic wards, each staffed by two Tier 1 doctors and supported by dedicated middle grade doctors, with an on-call registrar covering the week. While support was generally viewed positively, FY doctors noted that it can occasionally be difficult to contact middle-grade doctors when they are occupied in theatre.

Core & ST1-8: There is an online rota that clearly identifies the on-call consultant and registrar. They reported no issues in accessing support.

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

Trainers: RDITs benefit from a high volume and broad range of trauma cases across the 3 sites. Fracture clinics are prioritised, which limits access to elective theatre lists. A business case has been submitted to address staffing gaps, but funding is still pending approval. Advanced Nurse Practitioners (ANP's) are utilised to aid RDITs attendance at learning sessions.

FY: FY1s working within the Trauma Assessment Unit reported high service pressures and reduced clinical exposure due to an ongoing facilities issue.

FY2s reported good access to experience which they evidence using WPBAs when on call. However, when working on the ward, they are often the most senior doctor following the ward round. Opportunities to attend clinics or theatre were reported to be limited.

Core & ST1-2: We heard that Wishaw offers strong training opportunities in theatre. However, RDiTs within the core training programme reported that they are frequently required to leave theatre to provide ward cover which can limit their access to operative training opportunities. They described their role across the trauma sites as service delivery rather than training and reported limited clinic access and underdeveloped logbooks. A new consultant has taken over the rota and it is hoped this will improve training opportunities.

ST3-8: RDiTs recognised that the units are very busy following the merger of three sites, which at times can leave them feeling under-resourced. They told us consultants are keen to teach and aware of their training needs. There is strong exposure to both trauma and elective work, although getting to elective clinics can be difficult.

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

Trainers: Not asked due to time constraints

RDiTs: Reported within 2.6

2.8 Adequate Experience (multi-professional learning) (R1.17) Not asked, no concerns raised in PVQ

2.9 Adequate Experience (quality improvement) (R1.22) Not asked, no concerns raised in PVQ

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

Trainers: Formal feedback is initiated through ES/CS meetings, where development plans are agreed. There are dedicated sessions for Multi Consultant Reviews and WPBAs such as mini-CEXs. Informal feedback is embedded in practice, including trauma meetings where all cases are reviewed. If an RDIT raised concerns regarding feedback they are encouraged to discuss with their ES/CS.

Core & ST1-2: Most consultants are strong trainers and provide good feedback. However, the trauma meeting in Lanarkshire has a heavy workload, which limits opportunities for direct feedback. In theatre, consultants are generally supportive and will give feedback if there is time for one-to-one discussion. Senior registrars also encourage junior RDITs to get involved.

All ST3-8 RDITs: Not asked due to time constraints, no concerns raised in PVQ.

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

Trainers: Feedback on improvements is sought from all RDITs via email with a focus on clear, practical suggestions. It was noted that ISCP is being used in line with other sites.

All RDITs: FY's confirmed there are opportunities to provide feedback, they provided an example of a medical consultant spending time on the wards to ensure FY doctors had adequate support and that the workload remained manageable. Specialty doctors in training told us there were various surveys which they could feedback and through meetings with their allocated supervisors.

2.12 Culture & undermining (R3.3)

Trainers: Trainers reported that RDITs often return at later stages of their careers, with CTs progressing to ST roles and STs returning as consultants. There is a central hub where staff and RDITs can connect. The department has a zero-tolerance approach to bullying and harassment. At the time of review, there were no RDIT complaints or reported incidents. Active Bystander training has been delivered.

All RDITs: They described the team as approachable and friendly. They felt well supported and part of the team. FYs said doctors on the ward listened to any concerns they raised and actioned

appropriately. There were no reported issues with undermining or bullying behaviours within the last 6 months.

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

Trainers: Not asked due to time constraints

All RDiT: Across all training grades, RDiTs reported no significant formal rota gaps during their placement. FY doctors described the post as the best block they had experienced to date. However, some highlighted ongoing workforce pressures, noting that staffing levels could feel stretched at times, particularly at weekends, with wards often supported by a single ANP. Senior RDiTs also reported that known workforce gaps, including maternity leave vacancies, were not always backfilled promptly, which contributed to increased workload pressures.

2.14 Handover (R1.14)

Trainers: Trainers described a comprehensive electronic handover process using the E-Trauma system. There are formal handovers between consultants and middle-grade doctors with junior doctors contribute to morning ward handovers.

FY: FY's reported that morning handovers are generally well organised and effective, although some noted that the process can occasionally be unclear due to the volume of patients discussed.

Core & ST1-2: RDiTs reported that the quality of handover can be variable. Formal handover arrangements are in place between day, on-call and night teams, although occasional omissions in information transfer were noted. They suggested that a more structured ward-based review process could further strengthen handover. A formal ward handover document has been implemented and is used by the nursing team, although there was uncertainty if ANPs could access.

ST3-8: They told us morning handover was comprehensive, although often lengthy. Despite the pressures of a busy unit, they said the process was safe and effective for patient care.

2.15 Educational Resources (R1.19) Not asked, no concerns raised in PVQ

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) Covered in 2.18

2.17 Educational governance (R1.6, 1.19, 2.1, 2.2, 2.4, 2.6, 2.10, 2.11, 2.12, 3.1) Not asked, no concerns raised in PVQ

2.18 Raising concerns (R1.1, 2.7)

Trainers: Trainers reported that safety is embedded from induction onwards. They described an open culture where RDiTs can raise concerns informally or confidentially and are encouraged to speak directly with senior staff about any patient safety issues. Trainers felt that concerns would be recognised and addressed promptly through established support and reporting mechanisms.

All RDiTs: RDiTs reported that concerns would typically be raised in the first instance with senior ward staff. Consultants were described as approachable and responsive, with concerns taken seriously and acted upon appropriately through formalised channels.

2.19 Patient safety (R1.2)

Trainers: Not asked due to time constraints

FY: RDiTs reported that workload can at times present a perceived patient safety risk, particularly when ward staffing is limited to one FY2 and one ANP. Concerns were raised about the volume of patients expected to be managed by a single doctor, with up to 24 patients described as excessive. These concerns were raised and middle-grade support is sometimes provided to alleviate pressure.

CT1-2 & ST1-2: They were positive about operative care, some raised concerns about a lack of timely senior decision-making for unwell patients on the wards. The introduction of anaesthetic consultant reviews for high-risk perioperative patients was viewed positively, but examples were provided where RDiTs felt they needed to stay beyond their scheduled hours to ensure appropriate management plans were in place.

ST3-8: RDITs reported no concerns regarding the quality of surgical care. However, concerns were raised about wider system pressures, including long waits in the Emergency Department, limited theatre capacity, and delays in patient flow. Concerns were also expressed about the management of boarded patients, particularly around clarity of clinical responsibility.

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

Trainers: Not asked due to time constraints

All RDITs: They had not experienced an adverse incident but reported confidence that they would receive appropriate support through a supportive line manager and wider team.

2.21 Other: Specialty doctors in training and their trainers highlighted reduced exposure to elective work, with service pressures limiting training opportunities in this area.

3. Summary

The panel found no immediate concerns regarding patient safety, RDIT safety, supervision, culture, or workplace behaviour. RDITs consistently described supportive trainers, good surgical training opportunities and clear escalation pathways. However, concerns were identified around the consistency of induction, limited or variable formal teaching provision, difficulties accessing some training opportunities due to service pressures and challenges obtaining workplace-based assessments in some areas. Core Surgical doctors reported a less positive experience than specialty doctors, frequently describing service demands taking priority over education, reduced access to clinics and theatre, and feeling undervalued as doctors in training. Workforce pressures and the management of medically complex patients on orthopaedic wards were recurring themes.

Is a revisit required?	Yes	No	Dependent on outcome of action plan review
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Positive aspects of the visit:

- No immediate patient safety concerns relating to orthopaedic surgical care and no concerns about resident doctor in training (RDIT) safety at any site
- Approachable and supportive group of trainers across all sites. Strong enthusiasm to innovate and improve training in trauma and orthopaedics, supported by proactive and dynamic non-clinical management teams
- Positive workplace culture with a strong focus on training and education. No concerns around workplace behaviour were heard on any of the sites.
- The surgical experience for T&O RDITs at all sites was very positive in particular in terms of unscheduled operating
- Formal supervision is working well on all sites.
- There was evidence of ongoing work to improve induction, supported by management teams.
- Clear escalation pathways and processes are in place across all sites, supported by technology
- Feedback provided to T&O RDITs is valuable and well received
- No significant rota gaps were described on any sites. Work is ongoing across all sites to increase workforce numbers and support access to training for those in training programmes (e.g. ANPs, CDFs).

Less positive aspects of the visit:

- Ongoing work to improve departmental induction, with further development required. Challenges include ensuring consistency across the training year and that the induction process meets the needs of, and prepares, RDITs for work within the unit
- Local formal teaching is challenging across all sites. It needs to better meet the needs of RDITs and be more accessible, with support from senior consultant colleagues, while recognising ongoing workforce pressures.
- While the T&O RDITs reported a positive surgical experience, core surgical RDITs had a less positive experience which should be reviewed.
- FY doctors told us that achieving WPBAs was more challenging than in other areas.
- Workforce pressures are affecting all doctors and medical complexities of patients on inpatient wards poses challenges to services. There are perceived patient safety concerns in relation to management of medical problems on orthopaedic wards

4. Areas 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
4.1	Departmental teaching was largely registrar-led and noted to be inconsistent.	The department should review consistency and the balance of RDiT-led and consultant-led teaching to ensure teaching reflects curriculum requirements and RDiT stage.
4.2	Some ST RDITs reported delays obtaining logins and security access.	The department should review processes for IT and access permissions to ensure RDITs can fully undertake clinical and educational activities from the start of placement.

5. Requirements - Issues to be Addressed

Ref	Issue	By when	Resident doctor cohort in scope
5.1	Departmental T&O induction must be provided which ensures RDITs are aware of all of their roles and responsibilities and feel able to provide safe patient care. Handbooks or online equivalent may be useful in aiding this process but are not sufficient in isolation		FY, Core, ST1-2
5.2	A process must be put in place to ensure that any RDiT who misses their hospital induction session is identified and provided with an induction		FY, Core, ST1-2

5.3	Ensure that service needs do not prevent RDiTs from attending clinics and other scheduled learning opportunities		Core
5.4	T&O Staffing levels in wards and emergency areas must be reviewed to ensure that workload is appropriate and does not prevent access to learning opportunities including outpatient clinics		All