Scotland Deanery
Quality Management Visit Report

NHS Education for Scotland

Date of visit	16th May 2025	**Level(s)**	FY, GPST, CT
Type of visit	Triggered	**Hospital**	Western Isles Hospital
Specialty(s)	Whole site	**Board**	NHS Western Isles

Visit panel	
Mr Brian Stewart	Visit Lead – Associate Postgraduate Dean for Quality
Dr Gemma McGrory	Training Programme Director (TPD) – Internal Medicine Training
Dr Sneh Banik	Foundation Programme Director (FPD)
Dr Patrick Bowman	Trainee Associate
Mr Bill Rogerson	Lay Representative
Ms Gillian Carter	Quality Improvement Manager
In attendance	
Ms Patriche McGuire	Quality Improvement Administrator

Non-medical staff in attendance	1			
Trainers in attendance	4			
RDITs in attendance	FY: 3	GPST: 2	IMT: 0	CT: 1

Feedback session: Managers in attendance	Chief Executive		DME	√	ADME		Medical Director	
	Other: Executive Nurse/AHP Director/Chief Operating Officer, Associate Medical Director							√

Date report approved by Lead Visitor	3rd June 2025

1. Principal issues arising from pre-visit review:

Following review and triangulation of available data from the 2024 National Training Survey (NTS) and Scottish Training Survey (STS) at the transitional Quality Review Panel (QRP) in September 2024, General (Internal) Medicine, Trauma and Orthopaedic Surgery, General Psychiatry and Obstetrics and Gynaecology at the Western Isles Hospital were all identified as being in the bottom 10% of departments for survey data and therefore within scope for a Deanery visit. As these departments currently host the majority of the Resident Doctors in Training (RDITs) placed within the Western Isles Hospital it was decided that it would be both sensible and beneficial to meet with all RDITs at the site. This means that in addition to the specialties listed above General Surgery was also be included within the scope of the visit. The specific concerns identified at the transitional QRP were:

- General (Internal) Medicine: bottom 2% for change in scores in the NTS
- Trauma and Orthopaedic Surgery: bottom 10% in the STS
- General Psychiatry: bottom 10% in the STS
- Obstetrics and Gynaecology: bottom 10% in the STS

Some of the data of note is listed below – please note that this is from the transitional QRP in September 2024 as there was no new data available at the March 2025 data review due to small numbers of survey respondents:

- General (Internal) Medicine: Red flag for educational environment and teaching and lime flag for handover in All Trainee STS. Red flags for overall satisfaction, study leave and supportive environment and pink flags for induction and teamwork in All Trainee NTS.
- Trauma and Orthopaedic Surgery: Lime flag for handover in All Trainee STS. Green flag for handover in Foundation STS.
- General Psychiatry: Pink flag for equality and inclusivity in All Trainee aggregate STS. Red flags for educational environment and equality and inclusivity in GPST STS.
- Obstetrics and Gynaecology: Nil of note.
- Other: Generally green/lime flags for catering facilities, rest facilities and travel in STS.

Looking at combined data for the whole site, there was only 1 pink flag for induction with all other flags white, however scores had dropped somewhat in recent years with the site having seen multiple green flags in 2021 and 2022.

Free-text comments were also noted surrounding the themes of supervision, workload and discrimination.

The Deanery panel would wish to explore the above concerns as well as identifying any points of good practice for sharing more widely.

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.

The panel would like to thank the service leads and management for providing helpful background information regarding the structure of training at the site and the current opportunities and challenges in training at Western Isles Hospital.

2.1 Induction (R1.13):

Trainers: Trainers reported that there is a full-day induction organised by the site's postgraduate administrator including some Advanced Life Support (ALS) training and a second day is included if needed. This is attended by all RDITs. The induction is delivered by Clinical Support Nurses (CSNs) as well as other members of healthcare staff. Trainers recognised that the volume of information in the induction could be overwhelming and they have stopped adding new material, although they would like to add some material regarding culture due to some negative interactions between RDITs and administrative staff. Trainers were unsure if all departments offered a departmental induction, but could confirm that some departments did, for example in Obstetrics and Gynaecology an induction was given by a senior midwife.

RDITs: RDITs confirmed that they received a hospital induction and found this useful and comprehensive. RDITs felt the hospital induction was appropriate for the type of work they do which involves a lot of cross-cover. They did not receive departmental inductions and some felt this would have been useful especially if working as the only RDIT in a department.

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

Trainers: Trainers reported that all local teaching opportunities during the week were announced by the postgraduate administrator, however they were aware that RDITs could be prevented from attending due to staffing as there was a gap on the rota. A locum was being sought to improve this situation. In terms of regional teaching, RDITs were asked to request study leave to attend and trainers reported that it was usually possible to release them.

RDITs: RDITs reported that there was a lot of local teaching available including grand rounds, peer teaching and Emergency Department teaching, however most had attended little or none due to gaps on the rota. They described currently going through a very busy period. In terms of regional teaching, GPSTs were able to attend full days of teaching by requesting study leave, however others had difficulties being released from ward work and most had not attended any regional teaching. RDITs described feeling guilty about attending teaching as it made workload challenging for their colleagues on the ward.

2.3 Study Leave (R3.12)

Trainers: Not asked.

RDITs: RDITs reported that it was quite easy to access study leave considering the tightness of the rota. Study leave was generally approved although this left those remaining on the wards with a greater need to cross-cover.

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

Trainers: Trainers reported that previously they had specialty-specific supervision, however due to some consultants leaving they now cross-cover. Allocations are sent to them by the postgraduate administrator. In terms of understanding the curricula for different RDITs, trainers reported that there were updates available about the Foundation curriculum and they relied on the feedback of colleagues to build a picture of how RDITs were doing as all staff work closely together. They meet RDITs formally 3 times per block, but typically see them more frequently. Trainers noted that they do not provide educational supervision for GPSTs who are supervised by trainers in the practice or IMTs

who have educational supervisors based in Raigmore Hospital, Inverness. Some trainers felt that the situation of supervising RDITs in other specialties was sub-standard. Trainers received a variable amount of time for supervision with some reporting only having 0.25 sessions for 3 RDITs. They did not feel that any more time was available to extend these sessions.

RDITs: Not asked.

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 on-call duties were split by specialties and some consultants were on-call every second day. Out-of-hours supervision was provided by a GP and CSNs.

RDITs: RDITs found it quite easy to access supervision. As there are no STs on the rota they went straight to consultants who were mostly approachable although they reported a few exceptions to this. Nonetheless, RDITs reported having to work beyond their competence or experience daily or weekly due to the expectations upon them in this placement. They felt they were expected to do more of the work of a registrar, for example looking after patients in the High Dependency Unit (HDU) who had peripheral and central access compressors. They reported that if a central line was needing to be fitted they would call the anaesthetist who may be off-site although they would come in quickly. They also noted that consultants are not on the arrest team with FYs describing needing to lead arrest teams. Out-of-hours cover was provided by CSNs and the GP who covers the Emergency Department.

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

Trainers: Trainers were able to stay up-to-date on the Foundation curriculum by attending regular updates and felt the GP curriculum was very general so many activities were applicable to their learning. Trainers reported that provision was made for IMTs to attend clinics as they had a curricular requirement to do this, however other grades were not always present at clinics. Trainers felt that this was probably due to service pressures or lack of interest. There were limited opportunities to attend clinics in Obstetrics and Gynaecology as RDITs were often required to cover other specialties. Trainers reported never having seen a RDIT in a surgical clinic and assumed that RDITs were not interested in these. RDITs did not generally attend theatre which was supported by scrub nurses.

RDITs: FYs felt it was easy to achieve their competencies, but having them signed off was challenging. In terms of theatre or clinic access, surgical trainees were able to access theatre time however others had difficulties accessing any theatre or clinic time. RDITs reported that this was mainly due to staffing as there were too few staff for them to leave the ward, however there was also 1 consultant who did not allow RDITs into theatre. Additional challenges were described in terms of locum consultants whereby locum surgeons did not have access to the relevant portfolio and locums were less likely to trust RDITs to assist with theatre.

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

Trainers: Trainers reported that they encourage RDITs to complete their workplace-based assessments and these come to consultants directly as there are no STs at the site.

RDITs: RDITs had difficulties completing their workplace-based assessments as they had to be sent directly to consultants who were sometimes not available on the ward or did not have time to complete assessments.

2.8 Adequate Experience (multi-professional learning) (R1.17) – Not covered

2.9 Adequate Experience (quality improvement) (R1.22) – Not covered

2.10 Feedback to RDITs (R1.15, 3.13)

Trainers: Not asked.

RDITs: RDITs reported that they got some informal feedback, but this was variable by specialty.

2.11 Feedback from RDIT (R1.5, 2.3)

Trainers: Due to the small size of the hospital trainers reported that they had good contact with RDITs and were able to speak to them regularly about feedback as well as at their end of block

meetings. They also noted that there is a RDIT forum once per month and clinical concerns could be discussed at handover.

RDITs: RDITs reported that there was a RDIT forum once per month but it could be difficult to attend this due to workload.

2.12 Culture & undermining (R3.3)

Trainers: Trainers felt that the hospital had a friendly reputation and consultants were approachable. They were mindful of the fact that many RDITs were away from their normal base location when working at the hospital and could need further support. They encourage RDITs to report any concerns to their supervisor and any complaints can be directed to the postgraduate administrator.

RDITs: RDITs found the hospital to be generally friendly, but could think of some cases where they had been addressed in a demeaning way. They felt this was often due to stress amongst staff. If they wished to raise concerns regarding bullying or undermining they would speak to their educational supervisor or complete a datix report.

2.13 Workload/Rota (1.7, 1.12, 2.19)

Trainers: Trainers reported that FYs did not always know where they would be working each day till the morning as gaps need to be covered. Usually the RDIT allocated to Obstetrics and Gynaecology would be moved first. During the week any unexpected gaps would be filled by medical staffing and they usually look first for volunteers before asking RDITs to help cover gaps. Due to the geographical location of the site they do not have access to a larger pool of doctors so there is a need for RDITs to cover gaps. A Standard Operating Procedure is currently being devised for covering last minute gaps.

RDITs: RDITs reported that usually locums are used to cover gaps but there is not always a locum in post and currently a gap on the rota is unfilled. Gaps are therefore filled by cross-cover with the RDIT assigned to Obstetrics and Gynaecology usually covering other areas and a locum in Psychiatry usually working in medicine. Out-of-hours shifts are covered by members of the existing medical team as the geography makes it impossible to access other staff. RDITs felt that the hospital team were reasonable in offering time off in lieu however they did not always receive the days off they were

offered in exchange for extra shifts. They often felt obligated to cover shifts to the detriment of their wellbeing as they felt guilty about leaving colleagues unaided. RDITs reported that locum rates were poorer at the hospital than elsewhere and there was no payment for cross-cover. CSNs were described as also being short staffed and so used mainly to cover night shifts with only 1 working in the hospital during the day covering bed management. RDITs felt the staffing for workload in medicine was insufficient and unsafe as they felt the high workload was likely to lead to a mistake being made. They described feeling exhausted and regularly staying late and missing lunch breaks due to the workload. RDITs felt that 1 additional member of staff covering the AAU and 1 in Trauma and Orthopaedic Surgery would improve the workload.

2.14 Handover (R1.14)

Trainers: Trainers felt that handover was an example of good practice at the site as it takes place at 8am, 4pm and 8pm with all consultants and RDITs in attendance. Trainers felt it was comprehensive.

RDITs: Not asked.

2.15 Educational Resources (R1.19) – Not covered

2.16 Support (R2.16, 2.17, 3.2, 3.4, 3.5, 3.10, 3.11, 3.13, 3.16, 5.12) – Not covered

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: Trainers reported that they quality manage their training through discussions at morbidity and mortality (M&M) meetings and by gathering feedback on the educational programme. The programme is modified in response to feedback.

RDITs: RDITs did not remember receiving any guidance about raising concerns at induction, but felt they would speak to their TPD/FPD if they had a concern. Some concerns had been raised to TPDs/FPDs regarding difficulties in obtaining workplace-based assessments but otherwise RDITs had not raised any concerns so far.

2.18 Raising concerns (R1.1, 2.7)

Trainers: Not asked.

RDITs: RDITs reported that they had raised patient safety concerns about the rota at the RDIT forum and were advised that a clinical teaching fellow was being recruited to work 1 day per week, but they had not seen any improvement yet.

2.19 Patient safety (R1.2)

Trainers: Not asked.

RDITs: RDITs confirmed that they had patient safety concerns due to the lack of flexibility in both the medical and nursing rotas and would be concerned if their friend or relative was admitted to the hospital. They noted that their concerns were only related to staffing and workload and they had never witnessed any unsafe practices.

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

Trainers: Trainers noted that adverse events have previously been reported via the datix system, however this has just been replaced by a new system called ‘In Time’. The risk and governance review team will look through adverse incident reports and escalate as needed to Significant Adverse Event Reviews (SAERs). Generally the hospital has only 4-5 SAERs per year and recently these have not involved RDITs. RDITs receive electronic feedback on reports they submit and, if sensitive, the Associate Medical Director would meet with them for a face-to-face discussion.

RDITs: RDITs had not experienced an adverse incident, however they had experienced a de-brief following an arrest call. They would feel more comfortable speaking to a substantive consultant if they were involved in an adverse event rather than a locum.

3. Summary

Is a revisit required?	**Yes**	**No**	**Dependent upon outcome of Action Plan Review Meeting**

Positives

- Induction was universally praised for being comprehensive and helpful in preparing RDITs to work within the hospital.
- Handover has a set process which works well and ensures high attendance from the medical team.
- Study leave was easy to access when required with requests rarely declined.
- The hospital was perceived to have a friendly culture and a team-based, supportive environment.
- Due to its geography, the hospital offers unique training opportunities.

Negatives

- RDITs found the workload very high and felt stretched, for example regularly missing breaks and working beyond rostered hours, with gaps on the rota exacerbating this.
- There is a tension between service and training as pressures in providing the rota can lead to both routine and elective training opportunities being missed; this included access to teaching, completion of workplace-based assessments and access to clinics/theatre.
- Some examples of incivility were reported which were believed to be a result of pressures within the team.
- Educational supervisors had insufficient time in their job plans for the number of RDITs they were supervising.
- Clinical supervision across different specialties was challenging and RDITs were sometimes expected to act at an inappropriate level for their grade.
- The leadership of arrest teams by Foundation doctors was felt to be beyond their competence.

4. Areas of Good Practice

Ref	Item	Action
4.1	Handover takes place three times daily with all consultants and RDITs in attendance.	

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	Due to the cross-specialty arrangements regarding supervision, the site should review and clarify the educational and clinical supervision arrangements to ensure a clear understanding of who is providing supervision and that educational supervisors understand curriculum and portfolio requirements for their RDIT group(s).	

6. Requirements - Issues to be Addressed

Ref	Issue	By when	RDIT cohorts in scope
6.1	Medical staffing must be reviewed to ensure this is appropriate to safely manage the workload and that the workload does not prevent access to learning opportunities including local teaching and outpatient clinics/theatre.	16th February 2026	All

6.2	All staff must behave with respect towards each other and conduct themselves in a manner befitting Good Medical Practice guidelines.	16th February 2026	All
6.3	All consultants who are trainers must have adequate time within their job plans for their roles to meet GMC Recognition of Trainers requirements.	16th February 2026	Trainers
6.4	There must be appropriate senior support to enable RDITs to complete sufficient workplace-based assessments to satisfy the needs of their curriculum and to ensure RDITs are not expected to work beyond their competence.	16th February 2026	All