

## Report of undermining check to The Ipswich Hospital NHS Trust

This visit is part of the [GMC's remit](#) to ensure local education providers comply with the standards and outcomes as set out in *The Trainee Doctor*. For more information on these standards please see: [The Trainee Doctor](#)

<b>Check</b>	Undermining check
<b>Date</b>	4 November 2014
<b>Location Visited</b>	The Ipswich Hospital NHS Trust
<b>Team Leader</b>	Professor William Reid
<b>Visitors</b>	Dr Joanna Mountfield Dr Toby Reynolds
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### Purpose of the check

We are undertaking a series of checks to obstetrics and gynaecology departments and a number of surgical specialty departments across the UK to:

- explore undermining and bullying
- gain further insight into local and national challenges in addressing bullying and undermining of doctors in training
- explore the challenges faced when empowering victims of bullying and undermining to come forward.

We are also looking at ways in which sites have managed undermining and bullying concerns in order to learn and disseminate good practice to other local education providers.

These checks were prompted by an increasing number of undermining and bullying concerns reported to us. Our 2013 National Training Survey\* asked doctors in training if they had experienced bullying or undermining in the workplace; 13% reported that they had.

We selected 12 departments; six obstetrics and gynaecology and six surgical specialty departments to visit over a period of three months. We chose to focus on obstetrics and gynaecology and surgical specialties as these were areas where doctors in training reported a high proportion of concerns. The sites were chosen after analysis of our evidence which includes bi-annual Dean's reports, data from the 2013 and 2014 National Training Surveys, and evidence from the Joint Committee on Surgical Training and Royal College of Obstetricians and Gynaecologists and local intelligence from Local Education and Training Boards (LETB) and deaneries.

This check was one of six obstetrics and gynaecology checks and was undertaken at the Ipswich Hospital. The check comprised six meetings with: foundation and specialty doctors in training, higher specialty doctors in training, the Trust's senior management team, obstetrics and gynaecology consultants, student midwives, midwives and representatives from Health Education East of England.

## Summary of the organisation

The Ipswich Hospital NHS Trust is a single-site, medium size acute district general hospital in Suffolk, England. It provides hospital-based healthcare to more than 443,000 people who live in and around Ipswich and east Suffolk. The Trust employs 3,700 staff and has 552 beds in general acute, maternity, paediatric and neonatal services. The Trust's obstetrics and gynaecology unit is a busy department with 3,800 births per year. At the time of our check there were 11 doctors in training in obstetrics and gynaecology posts, including one foundation doctor and one trainee general practitioner. The Ipswich Hospital was identified as a site with evidence of previous undermining concerns in obstetrics and gynaecology which were being addressed by the Trust.

\*[http://www.gmc-uk.org/NTS\\_2013\\_autumn\\_report\\_undermining.pdf\\_54275779.pdf](http://www.gmc-uk.org/NTS_2013_autumn_report_undermining.pdf_54275779.pdf)  
[http://www.gmc-uk.org/NTS\\_bullying\\_and\\_undermining\\_report\\_2014\\_FINAL.pdf\\_58648010.pdf](http://www.gmc-uk.org/NTS_bullying_and_undermining_report_2014_FINAL.pdf_58648010.pdf)

## Summary of key findings

### Serious concerns raised during the check

We found three potential patient safety concerns during our visit, which must be addressed by the trust:

1.	Consultant presence on labour ward is infrequent. Consultants should be present on labour ward to ensure patient safety, provide supervision and maximise educational opportunities. This must be urgently addressed. (TTD Standard 1.3)
2.	The hospital pager or 'registrar bleep' is sometimes inappropriately delegated to junior tier doctors in training (FY2, ST1 and ST2). This must cease with immediate effect and consultants must be responsible for the registrar bleep when there are no available higher tier (ST3+) doctors in training. (TTD Standard 1.3)
3.	The frequent use of middle grade locum night cover in the obstetrics and gynaecology unit needs more active management and quality control by the Trust. In some cases locum doctors are not fully contributing to safe and effective working in the unit. (TTD Standard 1.3)

### Requirements

1.	<p>The Trust must address each of the serious concerns identified during the check:</p> <ul style="list-style-type: none"><li>■ A consultant must be present on labour ward at all times to ensure patient safety, provide supervision and maximise educational opportunities. This must be urgently addressed.</li><li>■ Consultants must be responsible for the registrar bleep when higher tier (ST3+) doctors in training are not available. The hospital pager or 'registrar bleep' must not be allocated to junior tier doctors in training (FY2, ST1 and ST2).</li><li>■ The use of middle grade locum night cover in the obstetrics and gynaecology unit must be more actively managed and quality controlled.</li></ul> <p>(TTD Standard 1.3)</p>
2.	<p>The use of outdated terminology to describe doctors in training and rotas (for example, 'SHO') must cease to be used. All documentation, guidance and rotas should be reviewed to ensure that this terminology is removed. The Trust should refer to GMC guidance on clinical supervision. (TTD Standard 1.2)</p>

## Recommendations

1.	The Trust should redevelop rotas for doctors in training to ensure an appropriate balance of service provision and education and training opportunities. Particular attention should be paid to rotas for junior tier doctors in training to ensure their specific training needs are addressed. (TTD Standard 5.1 and 5.4)
2.	The Trust's senior management team and obstetrics and gynaecology unit clinical leadership should investigate and plan for future service reconfiguration to effectively respond to a reduced allocation of obstetrics and gynaecology unit doctors in training over the long term. (TTD Standard 8.1)
3.	The Trust should implement a single, formalised, multi-professional handover arrangement in the obstetrics and gynaecology unit. Attendance at morning and evening handovers should also be incorporated into consultant job plans to ensure consultant presence at each handover. (TTD Standard 1.6)

## Findings

### Learning environment

1. Doctors in training reported an overall satisfactory education and training experience at the Trust, with good practical experience, exposure to a wide variety of patients and a supportive and friendly consultant and midwifery team. They explained that most obstetrics and gynaecology consultants are approachable and open to teaching and they feel comfortable to ask questions and seek help when needed. The College Tutor within the unit was universally acknowledged as a consultant who will go above and beyond to find suitable learning opportunities. Midwives were viewed as very supportive in providing useful learning experiences with good feedback and debriefing. We found positive working relationships between doctors and midwives and the doctors in training we met recommended Ipswich Hospital as a good place to train in obstetrics and gynaecology.
2. Midwives told us that this is a busy unit, which can be a steep learning curve for some doctors in training. Junior tier doctors in training (Foundation, ST1-ST2) are well supported by their higher tier colleagues (ST3+), but they felt that higher tier doctors in training need greater support from consultants, particularly at night. There is a perception amongst midwives that doctors in training are sometimes reluctant to call consultants for help for fear of being seen as not able to manage a situation independently. This is more prevalent in relation to particular consultants.
3. Some doctors in training told us that they were anxious before arriving at the Trust because of negative stories about the obstetrics and gynaecology unit from previous cohorts, particularly around problems with rotas and intimidating and undermining behaviours from senior consultants. However, the doctors in training we met had not

experienced difficult behaviours by consultants. We heard of some isolated incidents of unprofessional behaviours from other staff including operating department practitioners and consultants in other units. One individual doctor in training also reported feeling undermined by non-clinical staff in the Trust's Human Resources department when developing a job plan, which was perceived as hostile and unsupportive, with limited coordinated communication between staff. Doctors in training reported that undermining complaints are formally investigated by the Trust.

4. Doctors in training and midwives reported that obstetrics and gynaecology wards follow appropriate protocols and conform to national clinical guidelines. They did not report undermining by obstetrics and gynaecology consultants, but they felt that consultants in the unit are not a cohesive team and this negatively impacts the overall learning environment. They acknowledge that consultants are professional to each other in public, but doctors in training are sometimes caught between consultants' different clinical management. Changes to the unit's leadership team have reduced these behaviours.
5. The consultants we met consider themselves to be a cohesive team but recognise that that the unit is experiencing a lot of flux because of staff retirement and the recruitment of new consultants. They felt that inadequate staffing is a stumbling block to changing the team culture and working environment. They acknowledged that doctors in training may have witnessed difficult behaviours during this transition. They also explained that they respect different clinical management, but recognised that multiple changes of patient care plans could be interpreted as unprofessional and are not good examples of collegiate working.

## **Leadership and management**

6. The Trust's senior management team (SMT) and consultant body in the O&G unit have been open to feedback and have taken collective ownership of previously reported undermining concerns. The Trust has also implemented a number of changes to improve the educational environment for doctors in training, including changes to the clinical leadership within the obstetrics and gynaecology unit, mediation, training and group discussions. The change in clinical leadership is viewed by the SMT, doctors in training, consultants and midwives as having a positive impact. This has made decision making more distributed and equitable within the unit and enabled doctors in training to feel more confident in raising concerns about their training.
7. The SMT recognises that previously reported undermining in the obstetrics and gynaecology unit was caused by one or two individuals. As a response, the Medical Director and Director of Medical Education have discussed acceptable behaviours with the individuals and the Trust has provided targeted interventions including psychological support, mentoring and cross-specialty coaching. The SMT also explained that the process of investigating undermining behaviours has resulted in sustained changes to the behaviours of some individuals without requiring further interventions.

8. The newly appointed Director of Medical Education (DME) is proactively leading transformation within the Trust and is supporting change in specific areas such as obstetrics and gynaecology. The Trust has elevated the DME role to join the combined Trust board to raise the profile of medical education at board level and represent education and training matters at the top level of governance within the Trust. However, we found some leadership gaps in the obstetrics and gynaecology unit, with the Divisional Director post vacant and the College Tutor not appointed on a formal basis at the time of our visit.
9. The obstetrics and gynaecology Clinical Leads and Consultants we met have clearly taken on board previous undermining concerns and have made progress in addressing them. New opportunities for doctors in training to meet with the College Tutor and Clinical Lead have been set up to enable them to raise concerns issues about service delivery and education and training matters. Details of these meetings are shared with consultants to deal with sporadic incidents of undermining as and when they are reported. Doctors in training and consultants also have monthly meetings to share information about educational matters within the unit.
10. The consultants we met recognise the importance of good communication within the team. They felt that problems in the unit may have been ignored previously, but that undermining concerns have been brought to the fore and addressed by changing the way they communicate with doctors in training. The consultants recognise that there should be more opportunities for doctors in training and consultants to speak more informally, not just in formal planned meetings.

## Clinical supervision

11. We identified three potential patient safety concerns in this area, which were also impacting on the learning environment within the obstetrics and gynaecology unit:
  - Lack of consistent consultant cover on the labour ward.
  - The frequent use of locum night cover which did not fully contribute to safe and effective working in the unit.
  - The 'registrar bleep' (for higher tier doctors in training) is sometimes allocated to junior tier doctors in training by consultants.

**Requirement 1:** The Trust must address each of the serious concerns identified during the check:

- A consultant must be present on labour ward at all times to ensure patient safety, provide supervision and maximise educational opportunities. This must be urgently addressed.
- Consultants must be responsible for the registrar bleep when higher tier (ST3+) doctors in training are not available. The hospital pager or 'registrar bleep' must not be allocated to junior tier doctors in training (FY2, ST1 and ST2).
- The use of middle grade locum night cover in the obstetrics and gynaecology unit

must be more actively managed and quality controlled.

### Consultant cover

12. Doctors in training and midwives reported variable levels of consultant presence on the labour ward, with some consultants perceived to be more visible and available than others. Midwives explained that consultant presence on the labour ward is very dependent on the individual consultant, and that it sometimes feels like they are pestering some consultants to attend the ward. Doctors in training feel that help and supervision is available when needed from a service perspective, but not always for educational or assessment purposes. While they do not feel unsupervised, they consider that this impacts on their learning and that they would have better training opportunities if the consultants were more present. Some doctors in training also reported challenges in obtaining consultant sign off of their portfolio evidence. LETB representatives were aware of historical inconsistencies in consultant presence on the labour ward. The Trust's SMT highlighted that the appointment of four new consultants to the unit would alleviate these concerns and ensure 12 hour cover on the labour ward.
13. There is a general perception amongst doctors in training that consultants have unreasonably high expectations and demands of higher tier trainees to perform some consultant level responsibilities. We were told of instances where doctors in training have been expected to manage clinics when a consultant had arranged annual leave but not cancelled their clinic commitments. This has previously been reported as a patient safety concern but there is a perception that the Trust and unit leadership have not responded.

### Locum night cover

14. We were told that the obstetrics and gynaecology unit frequently uses locum doctors for night cover, but some locum doctors do not fully contribute to the safe and effective working of the unit. Some consultants and doctors in training felt that the standard of some locums is inadequate and that some are unresponsive to service demands during their shifts. Doctors in training also told us that some locum doctors attend night shifts immediately after completing day shifts in another hospital, before returning back to that hospital the following morning. They felt this represents a potential patient safety concern. Doctors in training have raised these concerns with consultants but they recognise the difficulty of filling rota gaps.

### Pager responsibility

15. Doctors in training and midwives told us that due to rota gaps there is sometimes no higher tier doctor in training available to take the 'registrar bleep' (for higher tier doctors in training), and that sometimes this is allocated to junior tier doctors in training because some consultants are reluctant to take the registrar bleep. The

consultants we met felt that was a generalisation based on hearsay or isolated incidents, but they recognise that this is a potential patient safety concern.

## Rotas and workload

**Requirement 2:** The use of outdated terminology to describe doctors in training and rotas (for example, 'SHO') must cease to be used. All documentation, guidance and rotas should be reviewed to ensure that this terminology is removed. The Trust should refer to GMC guidance on clinical supervision.

**Recommendation 1:** The Trust should redevelop rotas for doctors in training to ensure an appropriate balance of service provision and education and training opportunities. Particular attention should be paid to rotas for junior tier doctors in training to ensure their specific training needs are addressed.

**Recommendation 2:** The Trust's senior management team and obstetrics and gynaecology clinical leadership should investigate and plan for future service reconfiguration to effectively respond to a reduced allocation of obstetrics and gynaecology doctors in training over the long term.

16. We found some challenges with rotas, staffing and the workload of doctors in training, which in turn are creating flashpoints for undermining and unprofessional behaviours.

### Rotas design and staffing

17. We were told by doctors in training and midwives that rotas are designed mainly for service delivery, rather than for optimal education and training. Although doctors in training are able to meet required outcomes by the end of their placements, we found that this is a particular issue for the junior tier where specific training needs have not been accommodated for particular training grades (ie for GP doctors in training). Some doctors in training also felt that the week by week rota restricts their exposure to different consultants, particularly to some of the newly appointed obstetricians. They felt that being allocated to different wards each day provides variety but does not allow for continuity of patient care or learning.

18. LETB representatives are aware of the limited educational exposure to clinics caused by some rigid, service driven rotas. They acknowledge that there is limited specificity for individual doctors in training but are reassured that all doctors in training are meeting their expected competencies by the end of their placements. The LETB has raised the issue during Trust visits and has encouraged the Trust to set up tailored rotas for doctors in training appropriate for the different levels of training and curricula.

19. LETB representatives highlighted that changes to the clinical leadership within the obstetrics and gynaecology unit have facilitated improvements by redistributing responsibility for rota design and management. Previously rotas were managed by the clinical lead so doctors in training had few options to seek redress and subsequently

did not feel there was scope for flexibility. The LETB has identified challenges with working patterns, with reports of long working hours over consecutive days. The LETB has liaised with the Trust to encourage the development of new rotas that ensure adequate support and exposure in both obstetrics and gynaecology. They noted some initial small scale improvements.

20. We also noted some use of outdated terminology to describe doctors in training in rotas, for example, 'Senior House Officer' (SHO). This could lead to confusion about the expected level of competence of the doctor in training and concerns regarding supervision, especially when sharing on-call commitments.
21. Staffing gaps and a lack of sufficient middle grade doctors within the unit place significant pressure on rotas and have previously caused some tensions between staff. Doctors in training and consultants alike recognise that rotas would work more effectively if the unit had a full complement of staff. They explained that some past tensions and unprofessional behaviours had been caused by staff being asked to back fill rota gaps and in some cases forego time off due to reluctance among the unit leadership to employ locums. Consultants and registrars also reported feeling under pressure to fill gaps when there are sickness absences. Some doctors in training feel particularly pressured to act up to fill middle and higher tier rota gaps because some consultants have been unwilling to act down. Although these are isolated incidents, they reported feeling vulnerable and unsupported on these occasions.
22. Clinical leaders and consultants in the unit highlighted that cultural change within the unit has been hampered by the staff gaps and recent retirements. The Trust's SMT recognise the crisis in filling middle grade posts and the need to cover essential services and is responding to these challenges by advertising for replacement staff and investigating using allied health professionals to improve support.

#### Post allocations and service reconfiguration

23. The Trust's SMT and obstetrics and gynaecology clinical leadership recognises they need to plan for future service reconfiguration in light of ongoing reductions to the allocation of obstetrics and gynaecology doctors in training. The SMT explained that the unit has greater capacity for training but the national reduction of allocated doctors in training within the specialty means that the unit is vulnerable to rota gaps. As a result the unit fills rota gaps with locum and trust grade doctors. There is recognition that the Trust will need to explore different ways of working and that this may require increasing the number of consultants working in the unit.
24. Representatives from the LETB highlighted that the Trust has been particularly hit by gaps because doctors in training are aware of previous reports and perceptions of bullying and undermining. At the time of our visit the LETB was investigating the balance of post allocations across the East of England region using National Training Survey data to allocate posts to higher quality training units based on trainee feedback. This has not resulted in major changes to allocations, but there is recognition that the

Trust will need to prepare for a 20 per cent reduction in trainee allocations by making changes to service provision over the long term and not rely on locum doctors to fill gaps.

## Handover

**Recommendation 3:** The Trust should implement a single, formalised, multi-professional handover arrangement in the obstetrics and gynaecology unit. Attendance at morning and evening handovers should also be incorporated into consultant job plans to ensure consultant presence at each handover.

25. Doctors in training and midwives told us that changes to the grand round post-caesarean section morning meetings in the labour ward have made these more constructive and supportive learning opportunities. Midwives reported previously witnessing some public undermining of doctors in training by consultants during handovers. We were told that previous cohorts of doctors in training had found the morning meeting humiliating and uncomfortable, and that what had been intended as an educational meeting to reduce unnecessary caesarean sections had become a forum in which consultants 'named and shamed' doctors in training whose decisions they disagreed with. This had resulted in doctors in training not attending the grand round meetings. Midwives explained that the approach has changed perceptibly over the past few years as staff have changed. They consider that changes to the clinical leadership of the unit have facilitated the changing style of these meetings.
26. We found that some further improvements are needed to handover arrangements. Doctors in training and midwives confirmed that improvements could be made to align and rationalise handover arrangements. There are three separate morning handover arrangements for midwives, doctors in training and consultants, which creates challenges for continuity of clinical management. A single formalised, multi-professional handover arrangement, as is standard practice elsewhere in the UK, is not in place. We were also told that there is limited consultant presence at handover at other times of the day.

## Quality management

27. The Trust's SMT is very positive about their working relationship with Health Education East of England, and both Trust and LETB representatives highlighted constructive dialogue and engagement. The LETB acknowledges that the Trust has gone through a difficult period of redesigning their educational governance structure, which has resulted in significant change to the delivery of medical education and training at the Trust.
28. LETB representatives also recognised that the Trust has effectively addressed reported undermining concerns using formal investigation, appraisal and review processes. This approach has resulted in the removal of a senior consultant from leadership and educational supervision responsibilities in the unit. Since these changes no new

concerns have been reported. New mechanisms for engaging doctors in training and seeking their feedback have also been established in the unit, with monthly meetings between the clinical lead college tutor and doctors in training. A newly appointed trainee representative has also encouraged other doctors in training to speak up and help address concerns at a local level.

29. The LETB representatives we met felt that changes to the learning environment within the obstetrics and gynaecology unit are in their infancy but are demonstrating good progress. The Head of School for obstetrics and gynaecology at the LETB explained that actions taken by the SMT and consultant body have led to improvements over the past year, but cautioned that sustaining this progress will require vigilance and further evaluation. The LETB has recently received an updated action plan from the Trust with a commitment to appoint new consultants and change rota patterns within the unit. Doctors in training have also reported positive feedback to the LETB about the improving educational environment. This has also been identified in positive trends in the GMC's National Training Survey in the past two years.

## Conclusion

30. It is clear that the unit is making progress to address undermining concerns in the obstetrics and gynaecology unit since they were first identified in 2010. The Trust's SMT and obstetrics and gynaecology consultant body have implemented a number of changes to improve the educational environment for doctors in training, and changes to the clinical leadership in the unit have had a positive impact on the training ethos and culture. Doctors in training now feel more supported and confident to raise concerns about their training. Taken together, these interventions have created a more supportive and constructive learning environment, but some challenges remain.

31. The Trust continues to monitor and evaluate the training experience in the obstetrics and gynaecology unit, but there is a need for improvements to rotas, clinical supervision and handover arrangements. The trust must urgently address all of the serious concerns we identified and this must be followed up by the LETB.

### Monitoring

The Trust is responsible for quality control and will need to report on the actions taken regarding the requirements and recommendations in this report. The action plan must be sent to [quality@gmc-uk.org](mailto:quality@gmc-uk.org) and Health Education East of England by 24 March 2015. The LETB is responsible for quality management of the requirements and recommendations and must report on progress to the GMC via the annual Dean's Report process.