

Report of undermining check to North Devon District Hospital

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](#)

Check	Undermining and bullying checks
Date	28 November 2014
Location Visited	North Devon District Hospital, Northern Devon Healthcare NHS Trust
Team Leader	Mrs Jane Nicholson
Visitors	Professor Helen Sweetland Dr Toby Reynolds
GMC staff	Manjula Das, Education Quality Programme Manager Louise Devlin, Education Quality Analyst Charlotte Rogers, Education Quality Analyst

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 undermining and bullying of doctors in training
- explore the challenges faced when empowering victims of undermining and bullying 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 chose to focus on obstetrics and gynaecology and surgical specialties as doctors in training reported a high proportion of issues in these areas.

We selected 12 departments; six obstetrics and gynaecology and six surgical specialty departments to visit over a period of three months. The sites were chosen after detailed exploration of our evidence which includes Dean's reports, data from the 2013 and 2014 National Training Surveys, and evidence from the Joint Committee on Surgical Training (JCST) and Royal College of Obstetricians and Gynaecologists (RCOG) and local intelligence from Local Education and Training Boards (LETB) and deaneries.

This check was one of six surgical checks and was undertaken at North Devon District Hospital. The check comprised meetings with the hospital Senior Management Team (SMT) and a range of staff including doctors in training (trauma and orthopaedics, general surgery and anaesthetics) Consultants and clinical leads. We also spoke to representatives from Health Education South West via teleconference.

Summary of the organisation

North Devon District Hospital (NDDH) forms part of Northern Devon Healthcare NHS Trust. The Trust operates across a large geographical area, which comprises 17 community hospitals and nine health and social care teams across Torridge, North Devon, East Devon, Exeter, Mid Devon, Teignbridge and West Devon. Acute services are managed from North Devon District Hospital in Barnstaple which is also where the headquarters of the Trust are located.

Summary of key findings

Serious concerns raised during the check

1. One serious concern was identified during the visit. This was raised with the Trust and discussed with the LETB, Health Education South West during the check. Junior doctors training in trauma and orthopaedic surgery described an excessive workload, poor out of hours support and a lack of communication about rota changes. They indicated that

*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

this had emerged through the development of an out of hours cross-cover rota between general surgery and trauma and orthopaedics.

2. The Trust provided a written response to the GMC within a week of the check detailing their investigation of the concern and follow up actions taken. We were informed that the development of the cross-cover rota between general surgery and trauma and orthopaedics was in response to a reduction in the number of core surgical doctors in training (CSTs), from six to four in 2014. We were also told that this is expected to reduce further in August 2015, to two CSTs.
3. Following the CST reductions in 2014 and recognition by the Trust that there was no senior cover resident for orthopaedics which was required, two new rotas were piloted; one for foundation doctors in training and one for CSTs. Concerns regarding intensity of workload and potential negative consequences for patient safety were raised by trainees following the trial of the new rota arrangements. Changes were made to the core trainee rota to attempt to address these issues. From discussions with the trainees, it is clear that issues regarding the intensity of workload caused by the rota arrangements are ongoing. We heard that doctors in training are often looking after very sick patients across two departments, and that they feel unable to provide an appropriate level of care for patients in these situations. The Trust indicated in their response that further actions are being undertaken to address the concerns raised, including redesigning the rota with a planned implementation date of February 2015. The LETB should continue to monitor progress to address excessive workload, to ensure that this issue is appropriately resolved.

Good practice

1.	In response to notification of this visit, the Trust was proactive in addressing issues of bullying and undermining through the arrangement of a workshop for all staff within the surgical departments. Doctors in training and Consultants greatly valued this opportunity. (TTD Standard 6.18)
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Requirements

1.	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)
2.	Doctors in training must have timely access to senior support and there must be a clearly defined pathway for accessing this support at all times. (TTD Standard 1.11)
3.	The workload of doctors training in trauma and orthopaedic surgery must be reviewed to ensure that the intensity of work is appropriate in ensuring the delivery of high-quality, safe patient care. (TTD Standard 6.10)

Recommendations

1.	The Trust should review the out of hours handover arrangements within general surgery and trauma and orthopaedics, to ensure that they are appropriate in ensuring continuity of patient care. (TTD Standard 1.6)
2.	The Trust should closely monitor the working patterns and intensity of work for junior doctors in training to ensure that it is appropriate and compliant with European Working Time Regulations. (TTD Standard 2.1, TTD Standard 6.10)
3.	The Trust should ensure that education is reported to the local education provider (LEP) Board as a standing agenda item so that it is monitored. (TTD Standard 7.2)

Findings

Learning environment

Requirement 1: 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)

4. During the visit we met with foundation, core and higher specialty doctors in training in general surgery, trauma and orthopaedics and anaesthetics. We heard a mixed response from doctors in training about their access to educational opportunities at the hospital. Some doctors in training indicated that they have had a good overall experience at the hospital and are receiving sufficient theatre experience within the surgical units. We were pleased to hear that the colorectal unit has weekly learning activity meetings, which are beneficial to enable doctors in training to maximise their education and training opportunities. However, we also heard that service pressures often take priority over education and training.
5. Doctors in training reported that current staffing levels within surgical units are low and that there are rota gaps which have led to some doctors in training missing out on educational opportunities. The SMT confirmed that there have been instances of gaps in the rotas and that there are ongoing issues with recruiting non-training grade doctors. We also heard that the location of the hospital away from other more populated areas can pose some difficulties with recruitment of non-training grade doctors. The clinical leads we met described steps that have been taken to improve access to educational opportunities for doctors in training within surgical units. For example, trauma and orthopaedic clinics have been added to foundation doctors' timetables to ensure they are able to attend these on a regular basis.

6. We were also told by the clinical leads we met that opportunities for doctors in training to receive operating experience can be restricted by service pressures. Strict time constraints on operating sessions mean that there can be fewer opportunities for doctors in training within surgery to gain experience. Core trainees within general surgery supported this indicating that operations are mainly Consultant led and they would welcome more educational opportunities within theatre. Despite this, it was indicated that most consultants have been receptive to doctors in training raising issues about access to educational opportunities.
7. Throughout the visit the doctors in training we met with frequently used the term 'senior house officer' (SHO) and referred to SHO rotas. The term 'senior house officer' or 'SHO' provides ambiguity for doctors in training, members of the multi-disciplinary team and patients. This is due to the fact that it does not specify the level of training of the individual doctors and may lead to doctors being asked to work outside the limits of their competence or without appropriate supervision. The grades of doctors in training must therefore be used so that everyone has an awareness of the level of training.

Support for doctors in training

Requirement 2: Doctors in training must have timely access to senior support, and there must be a clearly defined pathway for accessing this support at all times. (TTD Standard 1.11)

8. In general the doctors in training we met with felt supported in their roles and valued the support provided to them by their educational and clinical supervisors. We heard that when available Consultants were approachable and that they had been able to raise any concerns they had with them.
9. Doctors in training felt supported in an educational capacity but we heard that some foundation doctors had experienced difficulty in accessing senior support, particularly when on call Consultants are in theatre and especially if advice is needed for the management of medical problems in orthopaedic patients. This correlates with what we heard from the SMT who indicated that the hospital has a small body of Consultants trying to do a variety of jobs. Foundation doctors told us that when Consultants were available they were very supportive but due to service pressures they were sometimes unavailable. In these cases when Consultants are not available there did not appear to be a clearly defined pathway for doctors in training to access senior support. An organisational understanding of where doctors in training should go when they need support should be agreed, communicated and implemented in the hospital. We also encourage the Trust to formalise arrangements for a sustained orthogeriatric service, which we heard was very supportive and beneficial to patients and doctors in training.

10. The clinical leads we met with also acknowledged that whilst there are no gaps in staffing at foundation doctor level, there are shortages of CST and non-training grade doctors. This correlated with what we were told by doctors in training. We heard an example of an anaesthetic doctor in training on call for ITU at the weekend being called by the surgical 'SHO' for help as there was no one else who could provide support to the trainee at that time.
11. Rota gaps were acknowledged as an issue by the SMT, who indicated that locum doctors are often used to fill these gaps. The doctors in training we met also raised the use of locum doctors to fill rota gaps as an issue, giving examples of locum doctors not turning up to shifts and sometimes being of a poor quality. We heard of instances where the clinical competency of some locum doctors had been called into question, and where junior doctors in training had not felt confident to approach them for support. It was acknowledged that the issue of poor quality locum cover had been raised with the management team and that appropriate action had been taken. Doctors in training were aware that work was ongoing to get more consistent, high quality locum doctors in place at the hospital.

Workload

Requirement 3: The workload of junior doctors training in trauma and orthopaedic surgery must be reviewed to ensure that the intensity of work is appropriate in ensuring the delivery of high-quality, safe patient care. (TTD Standard 6.10)

Recommendation 2: The Trust should closely monitor the working patterns and intensity of work for doctors in training within surgical units, to ensure that it is appropriate, and compliant with European Working Time Regulations. (TTD Standard 2.1, TTD Standard 6.10).

12. Trauma and orthopaedics doctors in training described a heavy workload and indicated that in some instances this had led to concerns for patient safety and trainee wellbeing. Discussions with the clinical leads acknowledged feedback from doctors in training that the cross-cover rota is not working and that there are plans for a new rota system to be implemented as of February 2015. The LETB were made aware of doctors in training concerns as part of the visit. The LETB should monitor the implementation of the new rota arrangements as of 2015 to ensure that the workload of doctors in training is appropriate in ensuring patient safety.
13. We also heard mixed views about compliance of the rota with European Working Time Regulations within general and trauma and orthopaedic surgery. We were told by doctors in training within general surgery that the rota was previously non-compliant and that recent work had been undertaken to improve this. In discussion with the clinical leads and in the response from the hospital regarding the serious concern raised, it was not clear if the rota is currently compliant. This should be ensured and

closely monitored by the Trust following the implementation of the new rotas in February 2015.

Handover

Recommendation 1: The Trust should review the out of hours handover arrangements within general surgery and trauma and orthopaedics to ensure that they are appropriate in ensuring continuity of patient care. (TTD Standard 1.6)

14. We heard from general surgery doctors in training that there are separate handovers for surgery and orthopaedics, despite there being a cross-cover rota for both specialties. This has resulted in doctors having to either provide two separate handovers for each department, or one doctor who is covering both rotas receiving two handovers. We heard that this is a problem for them and has resulted in difficulties in communication between the two departments.

Quality Management

Recommendation 3: The Trust should ensure that education is reported to the local education provider (LEP) board as a standing agenda item. (TTD Standard 7.2)

15. The SMT described the quality management processes that are in place to notify the LEP board of any issues that emerge concerning the delivery of medical education. We heard that the board always receives information regarding education and training and feedback following visits to the Trust by the LETB or external regulatory bodies such as the GMC. This information is communicated via reports from the Director of Medical Education (DME) to the Medical Director, who is a board member. Although the board will be briefed on any issues concerning education by the medical director it appeared that education is not considered as a standing item at LEP board level. It was acknowledged by all of those we met, including doctors in training that surgical departments at the hospital are currently under strain from rota gaps and service pressures, which can impact negatively on education and training. Education should therefore be considered as a standing item on the agenda at LEP board meetings to ensure that the sustainability of medical education, in line with service pressures is being appropriately considered on a regular basis.

Undermining and bullying

Good Practice 1: In response to notification of this visit, the Trust was proactive in addressing issues of bullying and undermining through the arrangement of a workshop for all staff within the surgical departments. Doctors in training and Consultants greatly valued this opportunity. (TTD Standard 6.18)

16. From our meetings with doctors in training, the clinical leads and the SMT, we found that there is neither a culture nor a systemic problem of undermining and bullying in the general surgery or trauma and orthopaedic units.

17. The SMT indicated that doctors in training usually report any experiences of bullying or undermining to their educational supervisor or clinical tutor in the first instance. The doctors in training we met with agreed that they would raise any bullying or undermining they experienced or witnessed with their educational supervisor. Foundation doctors told us that although they had felt able to raise concerns about the rota to their seniors, they had received little feedback from the Trust. They said that they would have felt more supported by active communication and involvement to identify potential solutions to their concerns.
18. Some doctors in training discussed witnessing or experiencing being shouted at by Consultants. One example given was when an on call Consultant has been asked to come in to review a patient and upon arrival the Consultant deemed it inappropriate that they were called in. In the examples given, it was largely acknowledged that these were isolated incidents that were a result of doctors in training being under a great amount of pressure, or due to sleep deprivation. The doctors in training clarified that this was not a regular occurrence or typical behaviour and was therefore not an ongoing issue. The majority of doctors in training we met with had not experienced undermining.
19. We were told by the SMT that an external facilitator from the Royal College of Surgeons was invited to deliver a workshop on bullying and undermining to surgical staff. This was recognised as a proactive approach to attempt to resolve any issues that were present within the hospital. The SMT clarified that this was arranged even though they were not aware of any current issues of bullying and undermining, but had been done in response to the GMC visit notification. Doctors in training found that this was a very useful session to encourage issues to be discussed, and for them to think about situations at work that may lead to instances of bullying and undermining and how to plan their work better as a team.

Conclusion

20. We were pleased to find no evidence of a culture of bullying or undermining in the general surgery or trauma and orthopaedic units.
21. The workload of doctors in training and the feedback from them regarding the impact of the cross-cover rota arrangements between general surgery and trauma and orthopaedics continues to be a concern. We were pleased to receive a response to this concern from the Trust indicating that from February 2015, rotas for general surgery and trauma and orthopaedics will be separate. We look forward to receiving an update regarding the implementation of these changes, and improvements to the workload intensity for trauma and orthopaedic doctors in training.

Monitoring

The Trust is responsible for quality control and will need to report on what action is being taken regarding the requirements and recommendations in this report. The action plan must be sent to quality@gmc-uk.org copying in Health Education South West by 02 April 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.