

Report of undermining check to Royal Victoria Infirmary, Newcastle upon Tyne Hospitals NHS Foundation 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](#)

Check	Undermining check
Date	24 October 2014
Location Visited	Royal Victoria Infirmary, Newcastle upon Tyne Hospitals NHS Foundation Trust
Team Leader	Professor William Reid
Visitors	Dr Jo Mountfield Jane Nicholson Dr Achyut Valluri Gillian Smith, Director of the Royal College of Midwives for Scotland attended as an observer
GMC staff	Kate Gregory, Joint Head of Education Quality Joe Griffiths, Education Quality Analyst Kim Archer, 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 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 issues. 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 Royal Victoria Infirmary. The check comprised six meetings with: foundation and specialty doctors in training (both obstetrics & gynaecology speciality trainees as well as general practice trainees), higher specialty doctors in training, the Trust's senior management team, obstetrics and gynaecology consultants, midwives and representatives from Health Education North East.

Summary of the organisation

Newcastle upon Tyne Hospitals NHS Foundation Trust is a large acute trust in Newcastle upon Tyne with six locations in the North East, including Royal Victoria Infirmary (RVI). It became a foundation trust in June 2006 and one of the largest NHS trusts in the UK. The Trust provides hospital and clinic-based healthcare to a population of 880,000 people in Newcastle upon Tyne and the Tyneside conurbation. The Trust employs nearly 13,500 staff and has 1,800 inpatient beds in medical, surgical, emergency and acute services. The

*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

obstetrics and gynaecology unit at Royal Victoria Infirmary is one of the UK's largest and busiest with nearly 7,500 births per year. At the time of our check there were 32 doctors in training in obstetrics and gynaecology posts, including two foundation doctors and five general practice trainees. Royal Victoria Infirmary was identified as a site with evidence of previous undermining concerns in obstetrics and gynaecology which were being addressed by the Trust.

Summary of key findings

Good practice

1.	Doctors in training are well supported with good supervision and excellent educational opportunities offering broad clinical exposure and experience. This is a high performing unit with a highly effective multi-disciplinary team. (TTD Standard 1.2, 5.1 and 6.17)
2.	The Trust's development of a professional behaviours and leadership framework integrated into the appraisal and performance system. (TTD Standard 6.32)
3.	The unit's leadership team is starting to make consultants' job planning more transparent at a departmental level. (TTD Standard 6.35 and 8.4)

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)
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Recommendations

1.	The Trust should investigate ways to relieve the pressure of workload on doctors in training, such as the introduction of non-clinical or multi-disciplinary roles. Further research should also be conducted to establish if doctors in training would benefit from defined period attachments in obstetrics or gynaecology. (TTD Standard 6.12 and 8.3)
2.	The Trust should implement more structured handover arrangements such as the Situation Background Assessment Recommendation framework (SBAR). Handover arrangements should include a round of introductions including name, grade and role of each individual on the shift. (TTD Standard 1.6)
3.	The trust should introduce organisational development time for the obstetrics and gynaecology consultant body as a group to improve cohesion and common direction in the department, and improve the working environment and education experience for doctors in training. (TTD Standard 6.36)

4.	The Trust should increase engagement and interaction between the unit's management team, the consultant body and the wider multi-professional team. The Trust should introduce regular face-to-face meetings between doctors in training, the consultant body and the unit's leadership team. (TTD Standard 2.3)
5.	The Trust and LETB should work together to strengthen their working relationship at a senior level, building on the strong relationships already in place between the Trust and the School of Obstetrics and Gynaecology. (TTD Standard 2.2, Standards for Deaneries 5.1 and 5.2)

Findings

Educational environment

Good Practice 1: Doctors in training are well supported with good supervision and excellent educational opportunities offering broad clinical exposure and experience. This is a high performing unit with a highly effective multi-disciplinary team. (TTD Standard 1.2, 5.1 and 6.17)

1. We found that the obstetrics and gynaecology unit at RVI is a busy unit with a significant increase in patient turnover in the past ten years. It is a high performing unit which provides excellent educational opportunities to doctors in training. The doctors in training we met agreed that they receive high quality training and they value their time at RVI. They reported good levels of supervision and support overall and all of those interviewed recommended the department as a place to train.

Working patterns

Recommendation 1: The Trust should investigate ways to relieve the pressure of workload on doctors in training, such as the introduction of non-clinical or multi-disciplinary roles. Further research should also be conducted to establish if doctors in training would benefit from defined period attachments in obstetrics or gynaecology. (TTD Standard 6.12 and 8.3)

2. There is general acknowledgement that national changes to work practices have resulted in loss of the traditional 'firm' structures in wards. However, the size of the obstetrics and gynaecology unit appears to be further exacerbating the situation, with consultants and doctors in training reporting limited opportunities to get to know each other. This is impacting on the broader educational environment. The consultant body suggested that doctors in training should be attached to obstetrics and gynaecology each for defined periods of time rather than working across both areas at the same time.

3. Though there are currently no gaps in the rota, there were gaps during spring 2014 with no appropriate locums available. The resulting increase in workloads and work pressure may have produced tensions and low morale, reflected in findings of the NTS. We did, however, hear there may have been undue pressure exerted on doctors in training to ensure rota gaps were covered, compromising their work/life balance.
4. Some doctors in training reported difficulties completing workplace-based assessments. They feel this is due to the competing demands of service delivery on their supervising consultants. They did not perceive this to be a lack of clinical support, in terms of consultant presence, or a lack of concern for their needs.

Multidisciplinary team working

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)

5. We found a highly effective multi-disciplinary team in the obstetrics and gynaecology unit. Though nurses and midwives report difficulties getting to know doctors in training when they are rapidly rotating, all felt that in an emergency the team work very well together and support each other. We heard excellent reports of multidisciplinary training activities to help build the team approach. There did, however, appear to be limited opportunity for team debriefing and sharing of learning after the event, mainly due to service demands and shift structures.
6. Nurses and midwives refer to all 'junior tier' doctors in training as 'SHOs'. This outdated term does not convey what level the doctor in training is at and what their likely capabilities are. Taken in combination with the reported difficulties getting to know doctors in training, this is likely to hinder effective communication within the team.

Handover

Recommendation 2: The Trust should implement more structured handover arrangements such as the Situation Background Assessment Recommendation framework (SBAR). Handover arrangements should include a round of introductions including name, grade and role of each individual on the shift. (TTD Standard 1.6)

7. Handover was highlighted as a previous forum for undermining. Previously, the senior doctor in training was responsible for relaying the outgoing consultant's management plan to the incoming consultant. Some doctors in training reported the incoming consultant inappropriately directing their disagreement with the management plan of the outgoing consultant at the doctor in training when they were relaying this at handover. However, this issue appears to have now been resolved by having both the outgoing and incoming consultants present at handover.

Reports of undermining or bullying

Good Practice 2: The Trust's development of a professional behaviours and leadership framework integrated into the appraisal and performance system. (TTD Standard 6.32)

8. Isolated incidents with nursing staff and midwives undermining doctors in training were identified, but did not appear systemic. These include comments made about doctors in training within the hearing of other staff which were intended to undermine the professional capability of the doctor in training. Doctors in training also highlighted issues with out-of-hours demands from the obstetrics wards, where a lack of co-ordination of requests results in frequent phone calls for non-urgent tasks. This could put a strain on relationships. Doctors in training reported that although they had escalated this issue, they did not feel that they were being listened to. There was also a wish for the Trust to explore of non-clinical or multi-disciplinary roles to help alleviate this pressure.
9. We heard reports of doctors in training having previously felt belittled by comments made during formal teaching at Grand Rounds. This reflects what doctors in training have previously reported to the LETB and the findings of the National Training Survey. It is not clear whether this was a deliberate or unintentional attempt to belittle or intimidate doctors in training. We also heard of certain consultants very publicly reprimanding doctors in training and delivering feedback on their actions in an unprofessional manner.
10. We did not find evidence of any direct threats, for example related to future employment prospects or any 'gatekeeping'-type bullying with reduced access to educational opportunities (e.g. operating lists or study leave). We did not hear of any bullying or undermining related to protected characteristics.
11. The Trust's senior management team acknowledges previous issues around unprofessional behaviours in the unit and has taken ownership of the problem. Clear statements were made that bullying and undermining are unacceptable and policies to reinforce this were highlighted. All doctors in training interviewed were aware of Trust policy on undermining/bullying and guidance on raising concerns via their induction programme. The Trust has also developed a professional behaviours and leadership framework integrated into the appraisal and performance system. It was developed with input from staff and explicitly states what is expected from staff about suitable behaviours.
12. We commend the current education management team, clinical director and college tutor for putting in place actions to investigate the reported undermining. They have explored novel ways to encourage reporting of bullying and undermining concerns and have put in place a more structured way of engaging with doctors in training, with a

monthly survey administered by the doctors in training. This is reportedly providing helpful feedback beyond the issues identified in the NTS.

13. The view of the senior management team was that previous unprofessional behaviours were borne out of a high pressure working environment. Training has been organised for the consultants to make them more aware of these behaviours and help develop better coping strategies. It is recognised that in the past there had been a failure on the part of the consultant body to recognise certain behaviours as undermining, as well as a failure to recognise the adverse effects on doctors in training. We consider that this could reflect the previously poor channels of communication between some consultants and some doctors in training.
14. We heard from the Trust's chief executive that there is a need to develop resilience amongst doctors in training so that comments intended as feedback are not perceived as bullying/undermining. We heard that reflective multidisciplinary groups are being developed to build team working and coping strategies.
15. At a departmental level the consultant body is open to feedback and committed to making changes to improve the educational environment for doctors in training. They have addressed the situations in which doctors in training felt undermined, such as ensuring outgoing as well as incoming consultant presence at handover meetings. They are also more aware of what can be perceived as undermining and how to recognise such behaviours. It is, however, not clear whether the whole consultant body is aware and able to access the personal development training the management team has organised.

Team cohesion

Good Practice 3: The unit's leadership team is starting to make consultants' job planning more transparent at a departmental level. (TTD Standard 6.35 and 8.4)

Recommendation 3: The trust should introduce organisational development time for the obstetrics and gynaecology consultant body as a group to improve cohesion and common direction in the department, and improve the working environment and education experience for doctors in training. (TTD Standard 6.36)

Recommendation 4: The Trust should increase engagement and interaction between the unit's management team, the consultant body and the wider multi-professional team. The Trust should introduce regular face-to-face meetings between doctors in training, the consultant body and the unit's leadership team. (TTD Standard 2.3)

16. Although the obstetrics and gynaecology unit's commitment to excellence of care is commended, the prioritisation of service and clinical efficiency has some unintended negative consequences for team cohesion within the unit. There appears to be a lack

of cohesion within the consultant body. Consultants told us that work pressures mean they seldom interact informally and they reported limited opportunities to come together as a team and input to collective decision making. As a result, doctors in training report feeling caught between consultant disagreements over treatment plans. Consultants also commented they have limited appreciation of each other's roles. In a bid to address this, we commend the unit's leadership team for starting to make job planning more transparent at a departmental level, but the consultant body would welcome more opportunities for organisational development time as a group to improve the educational experience for doctors in training.

17. We also identified a lack of engagement between the consultant body and the unit's management team. The consultant body reported following orders rather than co-creating solutions.

Relationships between LETB and the Trust

Recommendation 5: The Trust and LETB should work together to strengthen their working relationship at a senior level, building on the strong relationships already in place between the Trust and the School of Obstetrics and Gynaecology. (TTD Standard 2.2, Standards for Deaneries 5.1 and 5.2)

18. We recognise that the Trust and LETB have worked hard to improve relations, address concerns and ensure high quality learning opportunities for doctors in training. Health Education North East has offered support and staff training to help address undermining concerns in the obstetrics and gynaecology unit. Although we found a functioning working relationship between Health Education North East and the Trust we feel that there is potential for this relationship to be built upon and improved further. We heard that RVI is one of several units in region where the School allocates doctors in training with need for extra support. The fact that the unit provides training to doctors requiring additional support is positive, but it is recognised that this can put additional demands on the service. Additionally, implementation of the national policy of tariff for training posts has been seen to financially disadvantage the Trust. Reassuringly, there have recently been new appointments in the Trust, which appear to be fostering a more positive relationship with the LETB.

Conclusion

19. We were pleased to see the unit is making significant progress in creating a more supportive learning environment, with zero tolerance of undermining and bullying behaviour. It is evident from all participants that the Trust has created a better learning environment for doctors in training, and those we spoke to value this.
20. There is recognition that factors relating to the working environment, as well as factors related to individual characteristics have led to previous unprofessional behaviours. Though attempts have been made to address these, there are ongoing environmental

issues of high workload, external pressures to meet targets and lack of cohesion in the unit that need to be addressed.

21. The unit continues to monitor and evaluate the training experience, but overall the doctors in training that we met were positive about their experience at this Trust, with unanimous agreement that they would recommend the site to a colleague as a good training environment.

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 and Health Education North East 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.