

## Report of undermining check to West Middlesex University 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>	26 September 2014
<b>Location Visited</b>	West Middlesex University Hospital NHS Trust
<b>Team Leader</b>	Mrs Jane Nicholson
<b>Visitors</b>	Dr Joanna Mountfield Dr Toby Reynolds
<b>GMC staff</b>	Jennifer Barron, Education Quality Assurance Programme Manager Joe Griffiths, 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 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 West Middlesex University 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 North West London.

## Summary of the organisation

West Middlesex University Hospital is a busy acute hospital in West London, serving a local population of around 400,000 people. It covers the London Boroughs of Hounslow and Richmond upon Thames and neighbouring areas. The Trust employs over 1,800 people and has around 400 beds. The Trust's obstetrics and gynaecology unit is a busy department with 4,800 births per year. Under the North West London *Shaping a Healthier Future* strategy, the Trust has been designated as a major hospital, which will bring significant expansion and reconfiguration of services. At the time of our check there were 17 doctors in training in obstetrics and gynaecology posts, including two foundation doctors and five general practice specialty trainees. West Middlesex University Hospital was identified as a site with evidence of previous undermining concerns in obstetrics and gynaecology which are 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

### Good practice

1.	Senior specialty doctors have autonomy in organising their rotas. This has reduced perceptions of undermining at the unit. (TTD Standard 1.5)
2.	The introduction of handover between doctors in training in the obstetrics and gynaecology unit. This contributes to effective service provision and educational support and reduces the perception of undermining at the unit. (TTD Standard 1.6)
3.	The obstetrics and gynaecology unit continues annual monitoring of undermining and bullying concerns through an internal survey. (TTD Standard 2.3)

### Requirements

1.	The Trust must urgently investigate and address reported persistent intimidating and unprofessional behaviour in the organisation of the obstetrics and gynaecology junior tier rota. (TTD Standard 6.18)
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### Recommendations

1.	The Trust should introduce a planned programme of meetings for doctors in training and Consultants to meet as a group to discuss learning issues and non-clinical matters. The Trust should also communicate clearer guidance and advice on how to report non-clinical concerns at Unit and Trust level. (TTD Standard 2.3 and 6.7)
2.	The Trust should introduce a planned programme of meetings for doctors and midwives to meet as a group to discuss clinical and educational matters and provide opportunities for further engagement outside the clinical environment. (TTD Standard 5.19)
3.	The Trust should provide feedback to doctors in training on the outcomes of concerns entered into the Serious Untoward Incident reporting system to improve engagement with those using the system. (TTD Standard 6.7)

## Findings

### Learning environment

**Recommendation 1:** The Trust should introduce a planned programme of meetings for doctors in training and Consultants to meet as a group to discuss learning issues and non-clinical matters. The Trust should also communicate clearer guidance and advice on how to report non-clinical concerns at Unit and Trust level. (TTD Standard 2.3 and 6.7)

1. We found, for the most part a positive and supportive working and learning environment within the obstetrics and gynaecology unit. Doctors in training,

Consultants and midwives reported a flat managerial structure and good team working, which contributes to a supportive, open and nurturing place to work.

2. Doctors in training told us that they were anxious before arriving at the Trust because of negative stories about the obstetrics and gynaecology unit and the perception that Consultants and midwives were not very supportive, with unrealistically high expectations of doctors in training.
3. Some of the doctors in training we met had previously been on placement at the Trust. They reported that there had been previous incidents of unpleasant behaviour and evident interpersonal issues and personal conflicts between Consultants. However, their experience of training at the Trust was now much better.
4. Doctors in training are very visible in the unit and enjoy a good working relationship with the midwifery staff. Foundation doctors told us they can ask for advice and feel well supported by Consultants and more senior doctors in training.
5. The doctors in training and midwives we met felt that the unit provides a positive learning environment because senior Consultants and senior midwives have created a close knit, accessible and supportive culture, with good communication between staff and clear understanding of clinical roles. They felt that the unit's physical separation from the main hospital building creates a clear sense of identity and community for the unit. Colleagues look out for each other and there is good retention of midwifery staff and low rates of sickness absence, all indicators of a positive working environment.
6. The unit's clinical leaders told us that doctors in training are represented at monthly faculty meetings, with one trainee representative providing anonymised feedback and evaluation to Consultants.
7. The new clinical director meets with doctors in training as a group periodically on an ad hoc basis, but there is no specific forum for doctors in training to meet as a collective with Consultants. The doctors in training we met explained that more planned opportunities to discuss learning issues as a group with the unit's leadership team would provide a valuable way of maintaining the progress made by the unit in reducing perceptions of undermining and bullying. They felt that the Trust could provide better signposting about when and how to raise general issues and non-clinical concerns.

## **Leadership and management**

8. There is a highly visible and engaged senior management team at the Trust, which as a group have taken comprehensive action to address specific bullying and undermining issues previously identified.
9. The leadership demonstrated by the unit's college tutor and clinical director in engaging the Trust's senior management team helped to address the bullying and undermining issues identified in 2012. We heard that the Consultant body was

surprised by negative evaluation by doctors in training but have since taken collective ownership to reflect and change their approach to education and training within the unit. The Trust's subsequent substantial resource investment in the obstetrics and gynaecology unit, including funding for additional Consultants, has reduced pressures on service provision and created a more positive and supportive learning environment.

## Rotas and workload

**Requirement 1:** The Trust must urgently investigate and address reported persistent intimidating and unprofessional behaviour in the organisation of the obstetrics and gynaecology junior tier rota. (TTD Standard 6.18)

**Good practice 1:** Senior specialty doctors have autonomy in organising their rotas. This has reduced perceptions of undermining at the unit. (TTD Standard 1.5)

10. In 2012 the Trust undertook an external review of the obstetrics and gynaecology unit to investigate reported undermining concerns. The investigation found diffuse allegations of bullying or undermining by particular individuals. However in each of these cases, a key component of the reported undermining was the impact of a very heavy workload and the ineffective design and delivery of rotas which resulted in isolated instances of unprofessional behaviour.
11. The unit's clinical leadership explained that structural changes to the unit in 2011-13 resulted in an increased workload and patient numbers and changes to rota patterns. Subsequent focus on service delivery placed significant pressure on doctors in training and affected their education. Feedback at the time suggested that doctors in training were unhappy with the working arrangements.
12. Clinical leaders and Consultants within the unit explained previous challenges in recruiting to clinical fellow posts, which resulted in trainees allocated to intense 1 in 6 rotas. They felt that the busy, high pressure environment did not bring out the best behaviours in Consultants. Clinical leads highlighted previous challenges of applying appropriate rotas while still ensuring adequate supervision and workload.
13. In response to the review, the Trust has invested in an additional four Consultants, with six resident Consultants out of 17 in total. Rotas for doctors in training are now 1 in 8 with feedback from trainees that this is a preferable arrangement. Clinical leads and Consultants confirmed that the significant investment by the Trust, along with attitudinal change by Consultants, has helped to turn things around at the unit.
14. We heard that doctors in higher specialty training value the autonomy they have in organising their rotas. However, some doctors in training and Consultants reported intimidating and unprofessional behaviour by a named individual in the organisation of the junior tier rota. They told us these behaviours are prevalent in the monthly planning of the on-call rota, with a perception of limited recourse to reasonably challenge or change on-call allocations. The Consultant body reported this through

local processes and administrative staff have also submitted grievances, all without resolution.

15. Multiple staff members told us that the negative and unprofessional behaviours are ongoing and persistently demonstrated by the named individual and are having a destructive influence on the confidence of doctors in training and a negative impact on the quality of the training experience. There is a desire amongst clinical and non-clinical staff for rota responsibility to be transferred entirely to another individual. Senior staff in the unit are aware of the issues but this now requires urgent attention by the Trust.

## Clinical supervision

16. Doctors in training reported accessible Consultants and good clinical supervision. They think that the introduction of twenty four hour Consultant cover in the obstetrics and gynaecology unit with a resident consultant out of hours on-call system ensures they have adequate supervision and enhances their educational opportunities. All of the doctors in training we met agreed that they know how to access Consultants when needed. They told us that the shift towards resident Consultant cover allows them greater independence because they are secure in the knowledge that direct access to supervision is available.
17. Consultants told us that doctors in training are actively involved in supporting Consultants' clinical decision making. Sometimes it is difficult to engage doctors in training because of the heavy workload and service pressures. They felt that supervision has now improved given there is a Consultant physically present in the unit at all times.

## Handover

**Good practice 2:** The introduction of handover between doctors in training in the obstetrics and gynaecology unit. This contributes to effective service provision and educational support and reduces the perception of undermining at the unit. (TTD Standard 1.6)

18. The clinical leadership at the unit explained that changes to handover have been instigated as a result of the LETB's quality visits in 2012. Previously, the perception amongst doctors in training was that handover was used as an opportunity for Consultants to teach by humiliation and they were seen as particularly intense and awkward meetings. They told us the Consultant body was surprised by this feedback but crucially do not disagree with it and have taken ownership of the problem and the solution. They have reflected and made changes to their approach to make handover more sensitive to the needs of doctors in training.
19. We heard that multi-professional handover includes briefings each morning for staff to introduce themselves, allocate jobs and organise the lists. The introduction of trainee

to trainee handover is seen as a positive intervention to provide more constructive and less intimidating learning opportunities.

20. Doctors in training reported that the introduction of trainee to trainee handover, with support from Consultants, has reduced the perception of undermining reported by previous cohorts. It is thought that these arrangements are more effective for both service provision and educational support. Doctors in training told us that they enjoy handover and the new arrangements are supportive. Doctors in training told us that clinical disagreements are discussed privately and in a constructive and educational manner in a dedicated room to prevent embarrassment. There is a sense that these are useful and aid constructive clinical discussions during handover.

## Feedback

**Recommendation 2:** The Trust should introduce a planned programme of meetings for doctors and midwives to meet as a group to discuss clinical and educational matters and provide opportunities for further engagement outside the clinical environment. (TTD Standard 5.19)

**Recommendation 3:** The Trust should provide feedback to doctors in training on the outcomes of concerns entered into the Serious Untoward Incident reporting system to improve engagement with those using the system. (TTD Standard 6.7)

21. Doctors in training think that the provision of feedback can be improved. For example, they described inconsistent feedback from Consultants in situations where a doctor in training may feel undermined by the midwifery team in their clinical management. They also reported insufficiently detailed feedback following the report of Serious Untoward Incidents.
22. Doctors in training have not identified any concerns with undermining by Consultants. However, they highlighted a number of incidents where they felt side-lined by midwives in clinical decisions. They highlighted instances where Consultants had publicly sided with midwives to “keep the peace”, but then agree with the doctor in training’s approach in subsequent meetings. Doctors in training reported instances of Consultants siding with midwives’ during emergency situations, but then providing feedback after the event to confirm that the doctor in training’s clinical decision was the right course of action. There is a sense that while this can be used to diffuse difficult situations, it can also be classed as undermining. As a result doctors in training identify a need for more planned opportunities for doctors and midwives to discuss issues and address them in an open, honest and constructive way to facilitate better working relationships between doctors and midwives.
23. There is recognition of midwives as autonomous clinical practitioners by the doctors in training and acknowledgement of midwives’ empowered status within the unit. There is still a perception that midwives are resistant to input by doctors in training and are reluctant to involve them in clinical management for fear of alarming patients.

24. Doctors in training feel this is more prevalent in this unit than at other hospitals and can potentially create risks to patient safety in emergency situations. This has been reported via the Trust's incident reporting system but the doctors in training received no feedback and were unclear about any ensuing actions.
25. Doctors in training highlighted the extensive support and advice they are given in reporting Serious Untoward Incidents (SUIs). However, they feel the limited feedback they receive afterwards is vague and not useful for learning. They recognise they can take more individual responsibility in seeking appropriate feedback but consider that more targeted and personalised feedback from Consultants once SUIs have been fully investigated will help to improve their clinical practice.

## Quality management

**Good practice 3:** The obstetrics and gynaecology unit continues annual monitoring of undermining and bullying concerns through an internal survey. (TTD Standard 2.3)

26. There is a constructive working relationship between the Trust and the LETB, Health Education North West London. LETB representatives reported that the Trust's senior management team positively engages with LETB quality processes and is responsive to their feedback and evaluation. The LETB representatives we spoke to think that the new obstetrics and gynaecology clinical director provides new direction and leadership which fosters a more constructive learning environment at the unit.
27. The LETB has quality managed the Trust's reported undermining concerns since they were identified in 2012. Concerns were highlighted in negative outlier data in the National Training Survey and also reported during LETB quality visits to the Trust. The LETB conducted subsequent short notice checks to the unit in February 2013 to investigate the concerns and again in June 2013 to follow up on actions taken.
28. The Trust conducted internal surveys to identify what improvements were needed and put in place interventions relatively quickly. At the June 2013 visit the LETB found evidence of improvement, with doctors in training confirming that changes had been made.
29. LETB representatives feel that the Trust's investment in the unit has resulted in systematic changes to the working and education environment and provides a clear example of the importance of ensuring adequate staffing and resources for both service and training.
30. The unit's clinical leaders told us they continue to monitor undermining concerns using regular follow-up surveys to be assured that the changes made at the unit are sustainable. The Consultant body within the unit also use divisional meetings to present case study examples of what is working well and any areas for improvement.



31. The Trust's executive team highlighted multiple mechanisms for doctors in training to provide evaluation and feedback. The chief executive and executive team conduct 'walkabouts' in different wards on a weekly basis to meet staff, including doctors in training to identify issues that need resolving. The Trust's Education Governance Forum is attended by specialty tutors, the Medical Director, Director of Medical Education and Director of Nursing to review the educational experience across all professions using evidence from local surveys. The Trust also convenes a dedicated Junior Doctor Forum.
32. The Trust manages a clinical leadership programme for doctors in training to take on discreet projects to identify service and educational improvements. The Trust's 'Heads Up' project also focuses on how to escalate concerns and identifying improvements to multi-disciplinary working. Specific training sessions for foundation doctors on developing respectful working cultures are provided. This includes briefings on basic ward etiquette and building team relationships and is incorporated into the clinical leadership programme.

## Conclusion

33. It is clear that the unit has made significant progress since undermining concerns were first identified in 2012. The Trust is investing heavily to alleviate service pressures in the unit and the Consultant body has taken ownership and immediate action to change behaviours when undermining was first identified. Taken together, these interventions have created a more supportive and constructive learning environment. It is clear from all participants of this check that the Trust is creating a better learning environment for doctors in training and those we spoke to value these changes.
34. The unit continues to monitor and evaluate the training experience. There is still some scope for improvement, particularly in providing more opportunities for raising concerns and offering feedback to doctors in training when issues have arisen.
35. Overall, the doctors in training that we met are very positive about their experience at this Trust with unanimous agreement that they would recommend the site 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](mailto:quality@gmc-uk.org) and Health Education North West London 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.