QUALITY AND REGULATION TEAM
(LONDON AND SOUTH EAST)

NHS
Health Education England

Barts Health NHS Trust (Newham University Hospital)

Neonatology

Risk-based Review (on-site visit)

Quality Review report

Final Report

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Quality Review details

Background to review	The review was a follow up visit to Barts Health NHS Trust (Newham University Hospital) to assess the impact of the steps the Trust had taken to address the issues highlighted in the Health Education England (HEE) on-site visit on 19 April 2017. The most significant and concerning issue raised at that on-site visit related to bullying and undermining behaviour by a small number of neonatal consultant staff and the impact this had on the wider workplace culture. Since the visit in April 2017 the Trust has had an action plan to address these concerns and has been providing HEE with regular submissions to monitor the progress made. Prior to this review HEE held a confidential telephone surgery on 27 June 2018 for all neonatology staff (including trainees) to raise any concerns with the Deputy Postgraduate Dean that they would not feel comfortable raising in a public forum. No calls were received.
Training programme / learner group reviewed	Neonatology
Number of learners and educators from each training programme	The review team met with the following members of the Trust management team: • Medical Director • Managing Director • Director of Organisational Development • Managing Director, Education Academy • Director of Medical Education • Medical Education Manager • Clinical Director • Clinical Lead • Educational Lead & College Tutor • Neonatologiy consultant (RLH) • Director of Nursing (NUH) • Deputy Senior Nurse, Neonatal Unit • Associate Director of Nursing for W&C The review team met with the following trainees, as well as trust doctors and clinical fellows, who were either currently working in the Neonatal unit, or had recently rotated out of Neonates: • One Foundation Year 2 trainee • Four ST1-4 trainees; • One Clinical Fellow; and • Three non-training grade doctors The Chief Medical Officer and Chief Nursing Officer were present at the feedback session as the Trust Executive Board representatives.

Review summary and outcomes	The review team thanked the Trust for hosting and facilitating the review, for accommodating the request to allow members of the review team to visit the neonatal unit and for allowing the review team to meet with members of the nursing team at short notice. The review team was pleased to hear that the following areas were working well: • The review team was impressed to hear that the senior nursing staff for the neonatal unit had set up a successful weekly 'parental focus group' in addition to operating an 'open door policy' for parents and clinical staff. • The review team heard from the trainees that they were introduced to the nursing team at their induction and there was a proactive approach for nursing team to interact with trainees as easily approachable and supportive colleagues. • The trainees and trainers in the department were happy with the externally facilitated weekly grand round and a regular opportunity to discuss and learn from clinically challenging patients. The team would like to recognise the support from the consultant from the Royal London and to thank the Trust for supporting him in this practice. • The trainee focus groups facilitated by the Director of Medical Education (DME) at Newham University Hospital (NUH) were valued by the trainees and offered a 'safe space' for airing concerns. • The review team heard that the management of the rota was done proactively by a consultant in the department who provided guidance and oversight to a trainee who led on this. This allowed the trainees a degree of ownership and therefore in spite of 2/5 posts at core trainee level being unfilled, the risk to the clinical service was kept to a minimum. • The review team was pleased to hear that as part of the Trust wide culture change initiative, the Trust had appointed 'champions' to encourage good team working, cultural change and improve the staff experience. One member of the Unit had been appointed in this role. • The review team was pleased to hear of a regular programme of simulation-based learning which routinely involved all members of staff available and often were undertaken in the unit so staff were able to learn together. • The review team heard that there was an initiative in the Trust to train a cohort of midwives to undertake routine 'baby checks'. On shifts where a suitably trained midwife was available, the trainees found a significant reduction in their workload. This was becoming standard practice across many units nationally and the review team encouraged the Trust to continue to train appropriate numbers to make this a regular service. • However, the following areas were identified as of concern or in need of improvement: • The review team heard that there were only five substantive consultant Neonatologists in the unit, including two who had roles in Paediatrics and Neonatology. This had an impact on the nursing and consultant workload and made it stressful and often unmanageable. It was understood that the department had prepared a business case for the appointment of four substantive consultants with a minimum of 1.5 whole time equivalent

(WTE) being available to the Neonatology unit. The review team was concerned that the workload and staffing challenges were impacting adversely on the learning environment and staff morale and could potentially put patient care at risk.

- The review team heard that 10 neonatal nurses were often responsible for up to 30 patients, when this was due to be limited to 23. The review team was concerned that there was potential for patient safety to be jeopardised and that the stress on the service impacted upon staff morale and the department to maintain an effective training environment.
- The review team heard that staff, including trainees were usually too busy to be able to complete electronic documentation for adverse incidents/ near misses which were not reaching the thresholds for a serious untoward incident. When the forms had been completed there were no instances of useful or comprehensive feedback being provided to the person reporting, except for a confirmation email acknowledging receipt. There were likely to be missed opportunities for the whole team to learn from incidents and near misses and for the governance leads to identify any emerging trends.
- The team was aware of the recent departmental internal staff survey, which whilst highlighting many positives in the Unit also identified four areas of concern;
    - apparent lack of trust in the 'management' specially in terms of transparency and fairness;
    - a perception of favouritism;
    - lack of adequate and universal opportunities to undertake further training including leadership roles; and
    - nurses being asked to undertake inappropriate tasks.

  The review team heard of the 'Dignity at Work' initiative and champions of 'team working and behaviour' which the department was participating in.
- The review team heard that the consultants in the department were starting to rebuild their relationships and embedding values of mutual respect and trust with help of colleagues from the Royal London Hospital (RLH), the Education Academy and Organisational Development initiatives. The team felt that there was an awareness of the impact of dysfunctional teams on patient care and the learning environment and was pleased to find a genuine desire to engage with the improvement initiatives among the consultants. However, the review team shared their concerns that the trajectory in the improvement in the overall working environment in Neonatology may stall or fall away if scrutiny of the department ceases. It was indicated that the consultants welcomed the input from their colleagues at RLH and the OD interventions and HEE and would like to see this support continue.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean Health Education England for North London	**Head of School**	Dr Camilla Kingdon, Consultant Neonatologist and Honorary Senior Lecturer, Head of London Specialty School of Paediatrics and Child Health
External Clinician	Dr Ruth Shephard Consultant Neonatologist, Epsom and St Helier University Hospitals NHS Trust, Deputy Head of School and Training Programme Director, (ST1-3 South London Programme Management)	**Healthcare Representative**	Anna McGuiness Deputy Head of Clinical Education Transformation Health Education England
NHS Improvement Representative	Dr Emma Whicher Regional Medical Director NHS Improvement	**GMC Representative**	Jane MacPherson Education Quality Assurance Programme Manager General Medical Council
Trainee Representative	Dr Gary Foley The Royal London Hospital, Paediatric dept. and The Blizard Institute, Queen Mary University London	**Lay Representative**	Ryan Jeffs Lay Representative
HEE Representative	John Marshall Learning Environment Quality Co-ordinator Quality, Patient Safety & Commissioning Team Health Education England (London and Kent, Surrey and Sussex)	**HEE Representative**	Lynda Frost Head of Quality, Patient Safety & Commissioning Health Education England (London and Kent, Surrey and Sussex)
Observer	Andrea Dewhurst Quality, Patient Safety & Commissioning Manager Health Education England (London and Kent, Surrey and Sussex)		
Educational overview and progress since last visit – summary of Trust presentation			

The Trust management updated the review team on the progress made since the previous visit on 19 April 2017.

The review team heard that the Trust had undertaken a lot of work to engage with trainees and address the cultural issues that had long affected the Neonatology unit at Newham University Hospital (NUH). It was reported that the Trust management had met with trainees independently of their education and clinical supervisors to foster a 'safe space' environment so that trainees could air their concerns in a confidential environment. To supplement this, Trust management attended the Neonatology Local Faculty Group (LFG) meetings and maintained a visible presence in the department with a view to implementing a culture of continuous improvement.

Responding to previous allegations that individual consultants were the source of much of the tension in the department, particularly in relation to education and training, the review team heard that the Trust had conducted Managing High Professional Standards (MHPS) investigations. The investigations were conducted by an RLH Consultant, supported by an RLH HR colleague.

The review team heard that the investigation did uncover evidence of bullying and undermining behaviour, as well as underlying cultural issues across the department that affected team morale. However, the investigation did not uncover any concerns regarding clinical care. The Trust is currently working with named individuals to offer support, targeted training, development and objectives in order to assess suitability and reinstatement of the educational supervisor status.

The review team felt that the consultant body within the department had made a conscious effort to engage and support the trainees within the department. The review team were told that a RLH consultant will remain on hand to provide guidance and support to the Consultants and trainees in the Unit. The intent of the Trust was for the RLH consultant to continue in this role for the foreseeable future.

It was reported that there were several unfilled vacancies in the department but that this was not having an overly detrimental impact on the service or training opportunities. The review team heard that the large and diverse catchment area of NUH presented trainees with a wide ranging and complex case mix that was seen as a benefit in providing learning opportunities.

The Director of Organisational Development informed the review team that the Trust was working towards implementing a Neonatology-specific Behaviours Charter to agree consistent and high standards of professional behaviour and what was acceptable in the Unit. To tackle the concerns around a culture of silo working among the different professions in the department, The Trust had encouraged a more joined up approach and there were now regular meetings between the different profession leads in a multidisciplinary team (MDT) forum.

The Trust has launched an OD intervention for the whole site, using the NHSI Culture and Leadership framework. The programme is expected to last around two years and is intended to address some of the long standing cultural issues at Newham.

The review team heard that a launch conference had already taken place and that a six-month discovery phase was currently underway and that clinical and administrative staff at all levels across were represented in the exercise, with Neonatology staff represented on the programme Board.

With regard to patient safety, the review team heard that no further issues had been raised. There had been no serious incidents (SIs) in the previous financial year. There had been an SI in Obstetrics where Neonatology staff had been present. The review team heard that a hot debrief had taken place and there was recognition from the Trust that reporting systems and the training of them needed to be further developed. The review team heard that the Trust provided trainees with complex cases for discussion on a regular basis and had introduced a 'grand round' that included the MDT and parents.

The review team was impressed to hear that the senior nursing staff for the neonatal unit had set up a successful weekly 'parental focus group' in addition to operating an 'open door policy' for parents and clinical staff.

The review team was informed that an internal staff survey had been conducted and the results were in the process of being analysed. The Trust's next steps would include exploring how to share best practice, and in the case of Neonatology the Trust was hoping to plan an away day to build on the recent improvements of processes and workplace culture.

Findings

1. Learning environment and culture

HEE Quality Standards

1.1 The culture is caring, compassionate and provides safe and effective care for patients, service users, carers and citizens and provides a supportive learning environment for learners and educators.

1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in order to achieve the learning outcomes required by their curriculum or required professional standards.

1.3 The learning environment provides opportunity to develop innovative practice, engage in research activity and promotes skills and behaviours that support such engagement.

1.4 The learning environment delivers care that is clinically or therapeutically effective, safe and responsive, and provides a positive experience for patients and service users.

1.5 The learning environment provides suitable facilities and infrastructure, including access to quality assured library and knowledge services.

1.6 The learning environment and culture reflect the ethos of patient empowerment, promoting wellbeing and independence, prevention and support for people to manage their own health.

Ref	Findings	Action required? Requirement Reference Number
N1.1	**Patient safety** The review team heard of no specific incidents where patient safety had been jeopardised but the overall impression of the visit was that due to the staffing issues within the department the potential to put patient safety at risk was ever-present in the event of unforeseen staff absences.	
N1.2	**Appropriate level of clinical supervision** The review team heard from the trainees that they felt their clinical supervision was good. There was an acknowledgement that each supervisor had their own way of working but that it did not feel disjointed at handover. It was noted that there was synchronicity and continuity across the department and that there were guidelines in place.	
N1.3	**Rotas** The review team heard that the management of the rota was done proactively by a consultant in the department who provided guidance and oversight to a trainee who led	

	on this. This allowed the trainees a degree of ownership and therefore in spite of 2/5 posts at SHO level being unfilled, the risk to the clinical service was kept to a minimum. It was noted that the education leads were proactive in accommodating leave and study leave requests and arranging shift cover. The review team heard that there were two non-training grade doctor posts in the department but that despite the department being 'very busy', this was counteracted by a supportive environment across the senior doctors and wider Multidisciplinary Team (MDT).	
N1.4	**Induction** The review team heard that the department provided a substantial and wide-ranging induction process that lasted between two to three days. The induction included an introduction to the nursing team by the Deputy Senior Nurse in the Neonatal Unit and there was a proactive approach for the nursing team to interact with trainees as easily approachable and supportive colleagues. However, some trainees noted that the same could not be said of midwifery colleagues, with one trainee noting that they 'stumbled across' the midwifery team as they went on.	Yes, please see N1.4
N1.5	**Handover** The review team heard from the trainees that they felt the shift handover, usually at 16:30 was methodical and suitably carried out. However, it was reported that there had been issues around the handover between the Neonatal and Postnatal units and that the trainees had conducted their own informal audit and planned to reintroduce a formal handover procedure between the two units.	Yes, please see N1.5
N1.6	**Protected time for learning and organised educational sessions** The trainees reported enjoying a substantial and varied programme of practical and classroom based teaching and that they were required to sign attendance sheets. They felt that the Trust encouraged attendance of all training where possible and that their clinical supervisors supported this by arranging for cover, or providing this cover themselves.	
N1.7	**Access to simulation-based training opportunities** The trainees reported that they had access to simulated training. The review team heard that consultants devised cases and scenarios including the whole MDT team and that these would be run through to completion. It was noted that some exercises could include a large number of trainees and staff. The education supervisors confirmed that simulation training was scheduled for the last Monday of every month.	

2. Educational governance and leadership

HEE Quality Standards

2.1 The educational governance arrangements continuously improve the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

2.2 The educational, clinical and corporate governance arrangements are integrated, allowing organisations to address concerns about patient and service user safety, standards of care, and the standard of education and training.

2.3 The educational governance arrangements ensure that education and training is fair and is based on principles of equality and diversity. **2.4 The educational leadership ensures that the learning environment supports the development of a workforce that is flexible and adaptable and is receptive to research and innovation.** **2.5 The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership.**		
N2.1	**Impact of service design on learners** The trainees reported that there were two whole time equivalent (WTE) junior doctor vacancies in the department. This had resulted in trainees being asked to cover more shifts with increasing frequency in the past two months. It was reported that the department delivered around 6,300 babies in the 12 months prior to the review and that the department often operated at 120-40% of capacity. It was noted that beds in intensive care were used for this overflow. Where possible, patients were transferred to the Royal London Hospital, but the review team heard that the Royal London was often running over capacity too. It was noted that to manage occupancy levels across the Trust a teleconference was held each morning. The review team heard that there was an initiative in the Trust to train a cohort of midwives to undertake routine 'baby checks'. On shifts where a suitably trained midwife was available, the trainees found a significant reduction in their workload. This is becoming standard practice across many units nationally and the review team encouraged the Trust to continue to train appropriate numbers to make this a regular service. The education supervisors reported that maintaining a suitable level of service was at risk if unexpected absences in the department arose, particularly at consultant level. The review team heard that there were plans to address this by recruiting more staff. The department had requested for one WTE higher trainee and four WTE consultants. It was noted that two WTE consultants was a more realistic expectation and that it was hoped that 1.5 WTE would be allocated to Neonatology. It was noted that the consultants in the department were using their own personal connections to source ideal candidates for the roles, inclusive of support in obtaining visas. The review team was concerned that the workload and staffing challenges were impacting adversely on the learning environment and staff morale and could potentially put patient care at risk. The review team heard that ten neonatal nurses would often be responsible for up to 30 patients, when this was due to be limited to 23. The review team was concerned that there was potential for patient safety to be jeopardised and that the stress on the service impacted upon staff morale and the department to maintain an effective training environment. It was suggested that if the unit needed to run in excess of 100% of planned capacity for a significant period of time that the Trust would need to review and undertake the appropriate measures to run a safe and sustainable service. It was also reported that the Trust was looking at implementing new models of care to address the overcapacity issues across the three sites. During the session with the education supervisors three members of the review team went to observe the neonatal ward. They reported back that the organisation and camaraderie between staff from all professions that they observed was excellent and that the ward was highly functioning.	Yes, please see N2.1

N2.2	**Organisation to ensure access to a named clinical supervisor** The review team heard that the trainees had a named clinical supervisor, and where possible the clinical supervisor was also the education supervisor. The trainees reported that they enjoyed good relations with their supervisors and met with them regularly. The supervisors informed the review team that they each were responsible for three to four trainees and non-training grade doctors.	
N2.3	**Organisation to ensure access to a named educational supervisor** All trainees have access to a named educational supervisor.	
N2.4	**Systems and processes to identify, support and manage learners when there are concerns** The trainees felt that their workload was heavily weighted toward meeting service requirements when compared to other rotations they had worked in. This meant that on occasion the trainees felt that where reporting incidents on DATIX was required there was not a robust system in place to ensure that this was done. However, the trainees did not feel that this led to patient safety being jeopardised. When incidents were reported, the review team heard that these were acknowledged by the Trust but that there was not always a follow-up to ensure that incidents had been fully addressed or recorded satisfactorily. Where an incident had occurred it was discussed at handover but again, the trainees were unsure whether it was formally recorded and if it was it was usually reported by a member of nursing staff. However, the trainees reported that they felt that where escalation of an issue was required that their senior colleagues were on hand to provide assistance. The trainees also reported that issues could be raised and discussed at LFG meetings.	Yes, please see N2.4a and N2.4b

3. Supporting and empowering learners

HEE Quality Standards

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards and to achieve the learning outcomes required.

3.2 Learners are encouraged to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and service user-centred care.

N3.1	**Behaviour that undermines professional confidence, performance or self-esteem** The review team heard that the trainees had not experienced or witnessed any incidences of bullying or undermining. The trainees were aware of the longstanding cultural issues around bullying and undermining in the department but were surprised to hear that a recent survey conducted by the Trust found that some current staff still found the situation in the department unsatisfactory. One trainee did; however, report that when presented with	

	the opportunity to work in the department a number of years previously they had been deterred by the department's reputation.	

4. Supporting and empowering educators

HEE Quality Standards

4.1 Appropriately qualified educators are recruited, developed and appraised to reflect their education, training and scholarship responsibilities.

4.2 Educators receive the support, resources and time to meet their education, training and research responsibilities.

N4.1	**Sufficient time in educators' job plans to meet educational responsibilities** The education supervisors informed the review team that since the previous Health Education England (HEE) visit on 17 April 2017 there had been a wide-ranging internal discussion to address the cultural issues in the department. The review team heard that the Trust had acted upon trainee feedback and modelled the trainee rota to provide a more structured learning environment designed around trainee needs. It was felt that these positive changes had been reflected in the findings of the recent London School of Paediatrics 2017 survey. It was noted that the Trust had put emphasis on developing both the trainer and trainee experience and that this had resulted in both now working together more cohesively. The review team heard that the consultants in the department were starting to rebuild their relationships and embedding values of mutual respect and trust with clinical support from colleagues at the RLH, the Education Academy and HR for organizational development initiatives. The team felt that there was an awareness of the impact of dysfunctional teams on patient care and the learning environment and was pleased to find a genuine desire to engage with the improvement initiatives among the consultants. However, the review team shared their concerns that the trajectory in the improvement in the overall working environment in Neonatology may stall or fall away if scrutiny of the department ceases. It was indicated that the consultants welcomed the input from the RLH consultant.	

5. Developing and implementing curricula and assessments

HEE Quality Standards

5.1 Curricula assessments and programmes are developed and implemented so that learners are enabled to achieve the learning outcomes required for course completion.

5.2 Curricula assessments and programmes are implemented so that all learners are enabled to demonstrate what is expected to meet the learning outcomes required by their curriculum or required professional standards.

5.3 Curricula, assessments and programme content are responsive to changes in treatments, technologies and care delivery models and are reflective of strategic transformation plans across health and care systems.

5.4 Providers proactively engage with patients, service users, carers, citizens and learners to shape curricula, assessments and course content to support an ethos of patient partnership within the learning environment.

N5.1	**Opportunities for interprofessional multidisciplinary working** The trainees reported excellent working relationships with their nursing colleagues. The review team heard that they were generally approachable and offered help and support to trainees. It was reported that on Fridays a 'grand' round was conducted that was consultant led and included staff from all professions and grades, often including parents which was led by the RLH consultant. The round included discussions on complex cases and 'hot room' cases. The trainees found this a valuable learning experience and some trainees coming off shift at handover would stay late to participate. The review team was impressed to hear that the Matron for the neonatal unit had set up a successful weekly parental focus group in addition to operating an 'open door policy' for parents and clinical staff. The review team heard that there was a perinatal team meeting that they felt would be of educational value but that it was held early in the morning meaning that they were unable to attend.	

6. Developing a sustainable workforce

HEE Quality Standards

6.1 Recruitment processes to healthcare programmes fully comply with national regulatory and HEE standards.

6.2 Learner retention rates are monitored, reasons for withdrawal by learners are well understood and actions are taken to mitigate attrition of future learners.

6.3 Progression of learners is measured from commencement to completion for all healthcare learning programmes.

6.4 First destination employment is recorded and retention within first year of employment monitored, including the recording of reasons for leaving during the first year of employment.

6.5 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

N6.1	**Learner retention** The trainees reported that they would recommend the department as a training environment to their peers as the Trust provided lots of training opportunities and a supportive senior team and MDT colleagues. Whilst staffing remained an issue, the trainees acknowledged the Trust's attempts to address the situation. The review team heard that many of the trainees had found the busy nature of the department had built their confidence in tackling stressful situations and also noted that the opportunity for MDT working was a plus point in recommending the department to prospective trainees. A number of trainees also reported that they would consider remaining at, or returning to the Trust in the future as they progressed through their training.	

Good Practice and Requirements

Good Practice
• The review team was impressed to hear that the senior nursing staff for the neonatal unit had set up a successful weekly 'parental focus group' in addition to operating an 'open door policy' for parents and clinical staff. • The review team heard from the trainees that they were introduced to the nursing team at their induction and there was a proactive approach for nursing team to interact with trainees as easily approachable and supportive colleagues. • The trainees and trainers in the department were happy with the externally facilitated weekly grand round and a regular opportunity to discuss and learn from clinically challenging patients. The team would like to recognise the effort that the consultant from the Royal London was making and the Trust for supporting him in this practice. • The trainee focus groups facilitated by the Director of Medical Education (DME) at Newham University Hospital (NUH) were valued by the trainees and offered a 'safe space' for airing concerns. • The review team heard that the management of the rota was done proactively by a consultant in the department who provided guidance and oversight to a trainee who led on this. This allowed the trainees a degree of ownership and therefore in spite of 2/5 posts at core trainee level being unfilled, the risk to the clinical service was kept to a minimum. • The review team was pleased to hear that the Trust had undertaken a scheme for appointing 'champions' to encourage good team working, cultural change and improve the staff experience. One of the Unit had been appointed to this role • The review team was pleased to hear of a regular programme of simulation-based learning which routinely involved all members of staff available and often were undertaken in the unit so staff were able to learn together.

Immediate Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
	N/A		

Mandatory Requirements			
Req. Ref No.	**Requirement**	**Required Actions / Evidence**	**GMC Req. No.**
N1.4	The Trust should ensure that the induction process is formalised to include an introduction to, and interaction with midwifery colleagues.	The Trust should update trainee induction criteria to include an introduction to, and interaction with midwifery staff (similar to that embedded for the Nursing Team) and provide evidence of this to HEE.	R1.13

N1.5	The Trust should support trainees in their efforts to develop a pathway to ensure that a robust handover procedure is in place at the handover of patients from the neonatal unit to the paediatric unit.	The Trust should provide evidence of how it is supporting trainees to devise a safe pathway at handover between the neonatal and postnatal units.	R1.14
N2.1	The Trust should formulate an appropriate sustainable plan for the departmental workload and staffing situation to ensure that the clinical and learning environment is safe and manageable.	The Trust to keep HEE up to date with the staffing situation in the department and provide evidence of business planning activity.	R1.12
N2.4a	The Trust should ensure that feedback on reported incidents is provided in a timely manner and that a record is kept.	The Trust should ensure that trainees are aware of the processes for the recording of incidents and that trainees receive feedback when an SI is submitted in which they are involved and submit evidence of this to HEE.	R1.2
N2.4b	Schwartz rounds are an effective means of raising awareness of patient safety, learning from incidents/ near misses and fostering a culture of support and team working. The Trust should implement a Schwartz round-style process to embed the culture of patient safety awareness and learning together as an MDT,	The Trust to confirm that such Schwartz rounds are undertaken and provide evidence of trainee participation.	R3.2

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**	**GMC Req. No.**
	N/A		

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
N/A	

Signed	
By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty, Deputy Postgraduate Dean
Date:	14 August 2018

What happens next?

We will add any requirements or recommendations generated during this review to your LEP master action plan. These actions will be monitored via our usual action planning process. An initial response will be due within two weeks of receipt of this summary report.