NHS
Health Education England

Bart's Health NHS Trust (Newham University Hospital)

Neonatology

Risk-based Review (on-site visit)

Quality Review report

14 January 2019

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	Following the previous visits to neonatology at the Newham University Hospital site, it was felt that a follow-up on-site visit with the new cohort of trainees should be undertaken in early 2019, to gain feedback regarding their experience whilst in the department. This on-site visit was held on 14 January 2019.
Training programme / learner group reviewed	Neonatology
Number of learners and educators from each training programme	The review team met with four specialty trainees at grades one to five (ST1-5). The review team also met with neonatal clinical and educational supervisors, two senior nurses in neonatology and the following Trust representatives: • Chief Medical Officer, Alistair Chesser • Managing Director of Education Academy, Lois Whittaker • Associate Director for Quality, Stacey Forde • Medical Director, Sara Lightowlers • Managing Director, Tony Halton • Director of Medical Education, Emma Young • Deputy Director of Medical Education, Helen Parker • Medical Education Manager, Salma Akhtar • General Manager, Pooney Sekar
Review summary and outcomes	The review team thanked the Trust for hosting and facilitating the review. The review team was pleased to hear that the following areas were working well: • The approachability, support and mentorship provided by the consultants within the neonatology department. • Trainees acknowledged the favourable working relationship with the nursing staff in the neonatology department • The rich diversity of clinical and curriculum relevant opportunities for learning. • That the nursing workforce was adequate and that the attrition rate was exceptionally low. • The intervention of the Neonatal Matron and the Clinical Lead had led to an improvement in the neonatal resuscitation equipment related issues previously highlighted. However, the following areas were identified as of concern or in need of improvement:

	• Trainees acknowledged their responsibility for reporting serious incidents but informed the review team that they often felt too exhausted to complete the relevant documentation at the end of a shift. The review team felt that this had resulted in missed opportunities for the whole team to learn from incidents/near misses. However, the senior team was not aware of any emerging trends from SI reports around the management of deteriorating babies. • The review team noted that one of the key challenges for the trainees was managing an extremely high work load and service demands within the current staffing levels; the impact of which was felt to contribute to workplace stress and, potentially, deteriorating team behaviours. • The review team heard that the high level of workload had also impacted on the trainee's ability to undertake further career development, leadership and Quality Improvement (QI) opportunities; evidence of which may need to be provided at ARCP • The review team heard that some elements of the corporate induction process had been problematic; most notably these issues related to trainees obtaining personal smart cards, Occupational Health (OH) clearance, the completion of mandatory training modules and accessing IT systems within the department. • The review team heard that there was the potential for new trainees, without previous neonatal experience, to feel unsafe when using resuscitaires and when completing baby check tasks if sufficient training was not provided at their departmental induction. • The review team was disappointed to hear that the trainees felt that the historical culture around bullying and undermining amongst staff still prevailed. This was primarily related to interactions with a number of Trust appointed doctors in Neonatology and had also been experienced by trainees within the labour ward. • The review team heard that trainees were unaware of any improvement initiatives (i.e. team building events such as away day or behaviour charters) despite the concerted efforts from the Education Academy to resolve the issue. The review team recommended that the current enhanced monitoring of the department with monthly structured responses to HEE should continue. A further multi-professional visit was recommended for June 2019 to assess progress. The HEE London School of Paediatrics and Nursing Education Leads would be able to provide help and guidance in specific areas if required.

Quality Review Team			
HEE Review Lead	Dr Indranil Chakravorty Deputy Postgraduate Dean Health Education England for North London	**Head of School**	Dr Ruth Shepherd Consultant Neonatologist and Honorary Senior Lecturer,

			Deputy Head of London Specialty School of Paediatrics and Child Health
Training Programme Director	Dr Sunita Rao Neonatal Consultant Training Programme Director School of Paediatrics North Central and East London	**HEE Representative**	Julie Coombes Head of Clinical Education Transformation Health Education England (North London Local Office)
Observer	Andrea Dewhurst Quality, Patient Safety & Commissioning Manager Health Education England (London)	**Trainee/Learner Representative**	Dr Hannah Jacob Senior Trainee Representative
Lay Member	Jane Gregory Lay Representative	**HEE Representative**	Tolu Oni Learning Environment Quality Co-coordinator Quality, Patient Safety & Commissioning Team Health Education England (London)
Educational overview and progress since last visit – summary of Trust presentation			

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 was made aware of a range of near misses that had led to the delayed management of deteriorating babies. It was felt that this was, in part, a consequence of the clinical capabilities of a number of the Trust appointed doctors.	Yes, please see N1.1
N1.2	**Serious incidents and professional duty of candour** The review team heard that the trainees usually felt too exhausted to be able to complete electronic documentation for near misses that had not reached the threshold to be classified as a serious incident. The review team felt that there could be missed opportunities for the whole team to learn from incidents/near misses.	
N1.3	**Appropriate level of clinical supervision** The trainees informed the review team that there was always consultant presence when required and that clinical supervision was provided at all times. It was understood that trainees also had access to support from paediatric registrars within the department. The trainees reported that the level of clinical support received on-call was variable depending on which Trust grade doctor was on-call. The review team also heard that the trainees perceived there to be tension between themselves and the Trust appointed junior doctors and were concerned that this could have a negative impact on clinical practice and supervision. The review team heard that due to trainee concerns about the clinical abilities of a number of the Trust appointed doctors, there could be the potential to feel unsafe when working out-of-hours. The review team heard that the relationships between the trainees and Trust appointed doctors was negatively impacting upon team dynamics and patient safety. The review team welcomed the approachability, support and mentorship provided by the consultants within the neonatology department.	
N1.4	**Responsibilities for patient care appropriate for stage of education and training** The review team heard that there was an extremely high volume of workload that included baby checks (between 30-40 a day) within the neonatology unit. It was felt by the trainees that if they had arrived without previous neonatal experience that they may have felt unsafe when using resuscitaires and completing baby check tasks. The trainees reported that they would welcome additional training time on these areas within their departmental induction.	
N1.5	**Rotas** The review team heard that the rota was managed by a higher specialty trainee with support and guidance provided by one of the neonatal consultants. It was reported that despite the rota being 'fully staffed' based on current establishment, the department would benefit from additional staffing resources. The trainees also reported that there was an apparent disparity between the annual leave entitlement for them and the Trust appointed doctors.	Yes, please see N1.5

	The review team heard that there appeared to be a disparity in the distribution of clinical tasks between doctors. This had led to the perception that urgent clinical tasks were left undone or inadvertently delayed, for example, the review team heard of delayed discharge from the neonatal unit. This could impact on patient safety. The Clinical Lead (CL) confirmed that robust workforce discussions were held with the Trust Board and recruitment plans were underway for additional clinical support into the department.	
N1.6	**Induction** It was noted that all trainees had received a trust induction. The review team heard that trainees had experienced difficulties and delays with the trust induction, notably around the areas of obtaining smart cards, Occupational Health (OH) clearance, being able to complete the mandatory training modules and accessing hospital information technology (IT) systems. The review team heard that the trust had undertaken work to improve the formal departmental induction programme for trainees. The Education Lead (EL) informed the review team that new trainees to the department were inducted in all areas of the neonatology unit. It was noted that representatives from the maternity and midwifery leadership team had conducted dedicated sessions at induction. The review team heard that trainees were also provided with their induction schedules and rotas six weeks in advance. However, trainees without previous neonatal experience reported feeling unprepared when using resuscitaires and completing baby check tasks due to the lack of specific (hands-on) training. It was reported that plans were underway to incorporate specific induction training for the overseas and Trust appointed training grade doctors (about 50% of junior workforce) into the National Health Service (NHS) from January 2019.	Yes, please see N1.6 Yes, please see N1.6
N1.7	**Handover** The review team heard that trainees perceived handover meetings to be disorganised and cited examples that included a number of Trust appointed team members persistently arriving late and issues with the management and allocation of clinical tasks. The review team heard that a number of the trainees often felt unsafe out-of-hours, when supervised by some of the Trust appointed doctors due to inconsistent patient management and the trainees reported that they did not feel able to report these 'near miss' events using the electronic reporting systems. The EL reported to the review team that the neonatal consultant body recognised the concerns around the handover sessions but confirmed to the review team that there had been no risk to patient safety escalated to them. The review team was informed that the department held regular meetings (every Friday) where issues raised from the wider Multi-Disciplinary Team (MDT) were discussed.	Yes, please see N1.7a Yes, please see N1.7b Yes, please see N1.7c Yes, please see N3.1a
N1.8	**Protected time for learning and organised educational sessions**	

	The trainees confirmed to the review team that they were able to attend local and regional teaching programmes but reported that these were not bleep free. The review team heard that only training grade junior doctors attended these teaching sessions. The higher specialist trainees reported that they found it difficult to attend Friday afternoon teaching sessions as they coincided with the Friday Grand Round and the afternoon handover meeting. It was understood by the review team that trainees had requested the department to change the day and that this was being actioned.	Yes, please see N1.8
N1.9	**Adequate time and resources to complete assessments required by the curriculum** The review team noted that trainees were able to complete all the mandatory training modules in accordance with their curricula. It was understood that the department had a procedure in place for facilitating the documentation and competencies required for successful Annual Review of Competence Progression (ARCPs).	
N1.10	**Access to simulation-based training opportunities** The trainees reported that simulation sessions were incorporated into their rota. Trainees indicated that they found the sessions that were held in the simulation centre to be very useful. However, the review team heard that there were no sessions which involved the wider multi-professional team particularly simulation within the labour ward. It was noted that there could be improved opportunities for in-situ simulation. The higher specialty trainees reported being aware of plans to incorporate an in-situ simulation session specifically for trainees who had had difficulties accessing planned simulation sessions.	Yes, please see N1.10

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 review team heard that there was a low rate of exception reporting within the department. The higher specialty trainees acknowledged that the low rate of exception reporting was a widespread issue across the Trust and that the topic had been raised in the junior-junior meeting held in December 2018. The review team heard from the trainees that there was a difference in attitude from the Trust appointed doctors towards the completion of clinical tasks and that on	Yes, please see N2.1

	occasion this had resulted in additional workload for the specialty trainees. The review team heard that trainees would find additional information on the process for exception reporting to be valuable. The EL reported that there had only been two exception reports raised and that these related to trainees ending their shifts late. The EL also indicated that trainees were encouraged to leave on time.	
N2.2	**Organisation to ensure access to a named educational supervisor** The review team noted that all trainees had access to a named educational supervisor and were satisfied with the level of clinical supervision provided. The review team heard that the trainees agreed the consultant body was supportive and available at all times.	
N2.3	**Systems and processes to identify, support and manage learners when there are concerns** The review team heard from the CL that a number of the Trust appointed junior doctors did not wish to progress with their training despite the efforts to ensure access to equal opportunities for all doctors. The EL asserted that plans were in place to introduce a new electronic training portfolio to enable effective monitoring of the Trust appointed doctors' competencies.	
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 although the trainees found the breadth of clinical experience to be excellent, there would be reluctance to currently recommend the placement to a peer due to their concerns relating to the breakdown of team working, concerns regarding the competency of some trust appointed doctors and a degree of undermining in professional interactions amongst midwives and a number of senior nurses in the maternity unit. The review team also heard that trainees would not wish to have their own babies delivered nor would they recommend this unit for delivery to family and friends owing to their concerns around obstetrics/midwifery working practices and the clinical capability concerns about some doctors on duty. The review team heard that there was felt to be a division between training and trust-appointed junior doctors in the department and there were concerns from the trainees that this division could potentially result in unsafe clinical practices. It was also noted by the review team that trainees had experienced unprofessional interactions between staff when working within neonatology and midwifery. The review team heard that the department was aware of the tensions between trainee and Trust appointed doctors and it was reported that this had been discussed within consultant meetings.	Yes, please see N3.1a

	The review team noted that the nursing leadership team would provide feedback to the consultants on any shop-floor issues and confirmed that they were not aware of any concerns raised around team dynamics. The EL reported that there were plans in place to improve the team dynamics in terms of professional working across the department. The Director of Nursing for Women and Children (DNW&C) indicated that the paediatric unit worked closely with the Director of Medical Education (DME) to support the mitigation of any concerns raised around behaviours that could undermine interpersonal relationships amongst medical and nursing staff. The review team also heard the department planned to make improvements within the following areas: • Involvement from the wider multidisciplinary team across the neonatology and paediatric department; • Maintain harmony between training and Trust appointed junior doctors; and • Improve the progression of the Trust appointed junior doctors.	Yes, please see N3.1b
N3.2	**Access to study leave** The review team heard that trainees were provided with their rota in advance of commencing their roles so that they had the opportunity to book study leave. In addition to this, it was also reported that the rota coordinator within the unit prioritised trainee's study leave so that they were released to attend teaching sessions.	
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.**		
	N/A	
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.**		
	N/A	

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.

Good Practice and Requirements

Good Practice

- The review team praised the approachability, support and mentorship provided by the Consultants within the neonatology department.
- The trainees acknowledged the favourable working relationship with the nursing staff in the neonatology department
- The review team was pleased to hear that the placement offered a rich diversity of clinical and curriculum relevant opportunities for learning.
- The team heard that with the intervention of the Neonatal Matron and the Clinical Lead, there had been an improvement in the neonatal resuscitation equipment related issues previously highlighted.

Immediate Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
	n/a	n/a	

Mandatory Requirements

Req. Ref No.	Requirement	Required Actions / Evidence	GMC Req. No.
N1.1	The department is to undertake a review of all DATIX near miss incidents reported over the last three months to analyse any repeating trends.	The Trust to submit the results of this analysis as part of the monthly submission to the Quality team by 08 March 2019.	R1.2

N1.5	The Trust is to ensure that the rota-leave coordination is monitored weekly by a consultant/Rota manager.	The Trust to confirm the lead appointed for oversight and monitoring of the rota and leave coordination. The LFG minutes should include rota and leave as standing items, minutes to be submitted with monthly reports.	R1.12
N1.6	The department should implement a specialty specific induction programme (bleep-free and competency mapped) so that trainees can achieve the necessary clinical competencies to undertake their duties safely. The review team felt that this should be co-developed and delivered with out-going trainees, nurses and midwives.	The Trust to submit the agreed departmental induction and training programme for all trainees new to the department and new to the specialty and arrangement for competency sign off prior to commencing clinical duties. Please provide initial update by 08 March 2019.	R1.13
N1.7a	During formal shift handover, there should be timely completion of clinical and administrative tasks which are supervised by a consultant or middle-grade doctor using an electronic format that can be audited.	The Trust to submit an agreed (electronic) auditable Handover system which includes monitoring of tasks according to clinical priority and patient flow requirements with clinical oversight at consultant level. Progress in this action should be included in the monthly action plans.	R1.2
N1.7b	The department to initiate a regular, safe forum for raising concerns (e.g. Schwartz Rounds). These sessions should be led by consultants or an external facilitator with a structure that accommodates discussion around patient safety and allow any concerns to be raised.	The Trust to confirm a schedule of regular forum for raising concerns and lessons learned as part of the monthly submissions.	R1.2
N1.7c	The department should facilitate a learning culture by encouraging staff including doctors to report concerns through the established systems and increase awareness around whistleblowing.	The Trust to confirm a facilitated session for all trainees on raising concerns and Trust policy on whistleblowing has been completed and is thereafter included in the departmental / Trust induction. Progress will be evidenced in the March 2019 submission of Trust's outlined Action Plan to Health Education England (HEE).	R1.2
N1.8	The department to ensure that teaching sessions should be arranged at times that most trainees can attend, and these should be bleep free except for emergencies.	The Trust to confirm the schedule and attendance at the weekly bleep-free training sessions. Please provide initial update by 08 March 2019.	R1.17
N1.10	The department to ensure that in-situ, multi-professional simulation including management of deteriorating patient and human factors (team working, communication and situational awareness) becomes part of the regular teaching for the whole department. The department to put in place robust mechanisms for cascading	The Trust to submit a schedule of planned (minimum monthly) in-situ multi-professional / multi-specialty simulation sessions and confirm attendance candidate feedback and evidence to demonstrate that learning outcomes are focused on team learning, e.g. crisis resource management and identification of system errors /latent	R1.17

	learning to the benefit of trainees who had difficulties in accessing planned simulation sessions.	threats. This should also include maternity department. Please provide initial update by 08 March 2019.	
N2.1	The department to facilitate an open culture of exception reporting, provides refresher training in exception reporting from the Guardian of Safe Working Hour (GoSWH), undertakes in the Local Faculty Group (LFG a regular discussion of workload, trends from reports and impact on trainee well-being.	The Trust to confirm a session on awareness of Exception reporting is provided for all trainees, that this forms part of the Trust/ Departmental induction and that Exception reporting is included as a standing item in monthly LFG meetings. Confirmation should be included in the monthly submissions.	R1.3
N3.1a	The Trust to ensure that a co-developed charter of excellence in day-to-day interactions, respectful communication, supportive team-working and a high standard of professionalism mapped to the General Medical Council (GMC) Good Medical Practice should be implemented and that a Team Behaviour assessment tool should be utilized at regular intervals and monitored by Education Academy.	The Trust to include all junior medical and nursing staff in the organisational development workshops/ away days. These sessions should be facilitated by appropriately trained individuals and team behaviour metrics used to assess its impact. HEE would be happy to recommend Professional Support Unit support for developing these sessions and their assessment. Progress on this action should be part of the monthly reports to HEE.	R1.17
N3.1b	The Trust should urgently introduce improved collaborative working across Neonatal and Maternity departments. The review team felt that this should include a range of interventions including regular multi professional in-situ simulation sessions that were focused on structured respectful professional communication, leadership, team working and other relevant human factors.	See N1.10	R1.17

Recommendations			
Rec. Ref No.	**Recommendation**	**Recommended Actions**	**GMC Req. No.**

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

Signed

By the HEE Review Lead on behalf of the Quality Review Team:	Dr Indranil Chakravorty
Date:	21 February 2019

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.